State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-FIRST SESSION

H. F. No. 2184

03/07/2019 Authored by Liebling and Bierman
The bill was read for the first time and referred to the Committee on Ways and Means

A bill for an act

relating to state government; establishing the health and human services budget; modifying provisions governing children and family services, operations, direct care and treatment, continuing care for older adults, disability services, chemical and mental health, uniform service standards, health care, opioids, health-related licensing boards, Department of Health programs, adult protection, and medical cannabis; establishing OneCare Buy-In; establishing consumer protections for residents of assisted living; requiring licensure of assisted living; establishing dementia care services; making changes to home care licensing; requiring reports; making technical changes; establishing controlled substance registration requirement and registration fee; establishing councils; establishing OneCare Buy-In reserve account; modifying penalties; providing for rulemaking; modifying and making fees; making forecast adjustments; appropriating money; amending Minnesota Statutes 2018, sections 13.69, subdivision 1; 15C.02; 16A.724, subdivision 2; 62A.152, subdivision 3; 62A.3094, subdivision 1; 62J.497, subdivision 1; 119B.011, subdivisions 19, 20, by adding a subdivision; 119B.02, subdivision 7; 119B.025, subdivision 1; 119B.03, subdivision 9; 119B.09, subdivisions 1, 7; 119B.095, subdivision 2, by adding a subdivision; 119B.125, subdivision 6; 119B.13, subdivisions 1, 6, 7; 119B.16, subdivisions 1, 1a, 1b, by adding subdivisions; 144.0724, subdivisions 4, 5, 8; 144.3831, subdivision 1; 144A.071, subdivisions 1a, 2, 3, 4a, 4c, 5a; 144A.073, subdivision 3c; 144A.43, subdivision 6; 144A.44, subdivisions 1, 2; 144A.441; 144A.442; 144A.471, subdivisions 1, 5, 9; 144A.472, subdivision 7; 144A.474, subdivisions 9, 11; 144A.475, subdivisions 3b, 5; 144A.476, subdivision 1; 144A.4791, subdivision 10; 144A.4799; 144D.01, subdivision 4; 144D.015; 144D.04, subdivision 2; 147D.27, by adding a subdivision; 147E.40, subdivision 1; 147F.17, subdivision 1; 148.59; 148.6445, subdivisions 1, 2, 2a, 3, 4, 5, 6, 10; 148.7815, subdivision 1; 148B.5301, subdivision 2; 148E.0555, subdivision 6; 148E.120, subdivision 2; 148E.180; 148F.11, subdivision 1; 150A.06, by adding subdivisions; 150A.091, by adding subdivisions; 151.01, by adding subdivisions; 151.065, subdivisions 1, 2, 3, 6, by adding a subdivision; 151.252, subdivision 1; 151.47, by adding a subdivision; 152.01, by adding a subdivision; 152.10; 152.11, subdivisions 1, 1a, 2, 2a, 2b, 2c; 152.12, subdivisions 1, 2, 3, 4; 152.125, subdivisions 2, 3, 4; 152.22, subdivision 13; 152.25, subdivision 1c; 152.27, subdivisions 3, 4, 5, 6; 152.28, subdivision 1; 152.29, subdivision 3; 152.32, subdivision 2; 152.33, subdivisions 1, 2; 214.25, subdivision 2; 237.50, subdivisions 4a, 6a, 10a, 11, by adding subdivisions; 237.51, subdivisions 1, 5a; 237.52, subdivision 5; 237.53; 245.462, subdivisions 6, 8, 9, 14, 17, 18, 21, 23, by adding a subdivision; 245.4661, subdivision 9; 245.467,

subdivisions 2, 3; 245.469, subdivisions 1, 2; 245.470, subdivision 1; 245.4712, subdivision 2; 245.472, subdivision 2; 245.4863; 245.4871, subdivisions 9a, 10, 11a, 17, 21, 26, 27, 29, 32, 34; 245.4876, subdivisions 2, 3; 245.4879, subdivisions 1, 2; 245.488, subdivision 1; 245.4889, subdivision 1; 245.696, by adding a subdivision; 245.735, subdivision 3; 245A.02, subdivisions 5a, 18; 245A.04, by adding a subdivision; 245A.14, subdivisions 4, 8, by adding subdivisions; 245A.151; 245A.16, subdivision 1; 245A.40; 245A.41; 245A.50; 245A.51, subdivision 3, by adding subdivisions; 245A.66, subdivisions 2, 3; 245C.02, subdivision 6a, by adding subdivisions; 245C.03, subdivision 1, by adding a subdivision; 245C.05, subdivisions 5, 5a; 245C.08, subdivisions 1, 3; 245C.10, by adding a subdivision; 245C.24, by adding a subdivision; 245C.30, subdivisions 1, 2, 3; 245D.03, subdivision 1; 245D.071, subdivision 1; 245D.081, subdivision 3; 245E.06, subdivision 3; 245H.01, by adding subdivisions; 245H.03, by adding a subdivision; 245H.07; 245H.10, subdivision 1; 245H.11; 245H.12; 245H.13, subdivision 5, by adding subdivisions; 245H.14, subdivisions 1, 3, 4, 5, 6; 245H.15, subdivision 1; 246B.10; 252.275, subdivision 3; 252.41, subdivisions 3, 4, 5, 6, 7, 9; 252.42; 252.43; 252.44; 252.45; 254A.03, subdivision 3; 254B.02, subdivision 1; 254B.03, subdivisions 2, 4; 254B.04, subdivision 1; 254B.05, subdivisions 1a, 5; 254B.06, subdivisions 1, 2; 256.01, subdivision 14b; 256.478; 256.9365; 256.962, subdivision 5; 256.969, subdivision 9; 256B.04, subdivisions 21, 22; 256B.055, subdivision 2; 256B.056, subdivision 3; 256B.0615, subdivision 1; 256B.0616, subdivisions 1, 3; 256B.0622, subdivisions 1, 2, 3a, 4, 5a, 7, 7a, 7b, 7d; 256B.0623, subdivisions 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, 12; 256B.0624, subdivisions 2, 4, 5, 6, 8, 9, 10, 11; 256B.0625, subdivisions 3b, 5, 5l, 13, 13e, 13f, 17, 19c, 23, 24, 42, 45a, 48, 49, 56a, 57, 61, 62, 65, by adding subdivisions; 256B.064, subdivision 1a; 256B.0644; 256B.0659, subdivision 21; 256B.0915, subdivisions 3a, 3b; 256B.092, subdivision 13; 256B.0941, subdivision 1; 256B.0943, subdivisions 1, 2, 3, 4, 5, 6, 7, 8, 9, 11; 256B.0944, subdivisions 1, 3, 4, 5, 6, 7, 8, 9; 256B.0946, subdivisions 1, 1a, 2, 3, 4, 6; 256B.0947, subdivisions 1, 2, 3, 3a, 5, 6, 7a; 256B.0949, subdivision 2, by adding a subdivision; 256B.49, subdivision 24; 256B.4914, subdivisions 2, 3, 5, 6, 7, 8, 9, 10, 10a; 256B.69, subdivision 6d; 256B.76, subdivisions 2, 4; 256B.766; 256B.767; 256B.85, subdivision 3; 256I.04, subdivisions 1, 2f; 256I.06, subdivision 8; 256L.03, by adding a subdivision; 256L.11, subdivision 7; 256R.02, subdivisions 8, 19; 256R.16, subdivision 1; 256R.21, by adding a subdivision; 256R.23, subdivision 5; 256R.24, subdivision 3; 256R.25; 256R.26; 256R.44; 256R.47; 256R.50, subdivision 6; 260C.007, subdivision 18, by adding a subdivision; 260C.178, subdivision 1; 260C.201, subdivisions 1, 2, 6; 260C.212, subdivision 2; 260C.452, subdivision 4; 260C.503, subdivision 1; 518A.32, subdivision 3; Laws 2003, First Special Session chapter 14, article 13C, section 2, subdivision 6, as amended; Laws 2017, First Special Session chapter 6, article 3, section 49; article 8, sections 71; 72; article 18, section 2, subdivisions 1, 3, 5, 15; proposing coding for new law in Minnesota Statutes, chapters 119B; 144; 144A; 145; 148; 151; 245; 245A; 245D; 256; 256B; 256L; 256M; 256R; 260C; proposing coding for new law as Minnesota Statutes, chapters 144I; 245I; 256T; repealing Minnesota Statutes 2018, sections 119B.16, subdivision 2; 144A.071, subdivision 4d; 144A.472, subdivision 4; 144D.01, subdivisions 2a, 3a, 6; 144D.04, subdivision 2a; 144D.045; 144D.06; 144D.09; 144D.10; 144G.01; 144G.02; 144G.03; 144G.04; 144G.05; 144G.06; 214.17; 214.18; 214.19; 214.20; 214.21; 214.22; 214.23; 214.24; 245.462, subdivision 4a; 245E.06, subdivisions 2, 4, 5; 246.18, subdivisions 8, 9; 252.41, subdivision 8; 252.431; 252.451; 254B.03, subdivision 4a; 256B.0615, subdivisions 2, 4, 5; 256B.0616, subdivisions 2, 4, 5; 256B.0659, subdivision 22; 256B.0705; 256B.0943, subdivision 10; 256B.0944, subdivision 10; 256B.0946, subdivision 5; 256B.0947, subdivision 9; 256B.431, subdivisions 3a, 3f, 3g, 3i, 13, 15, 17, 17a, 17c, 17d, 17e, 18, 21, 22, 30, 45; 256B.434, subdivisions 4, 4f, 4i, 4j; 256L.11, subdivision 6a; 256R.36; 256R.40; 256R.41; Laws 2010, First Special Session chapter 1, article 25, section 3, subdivision 10; Minnesota Rules, parts 2960.3030, subpart 3; 3400.0185, subpart 5; 6400.6970; 7200.6100; 7200.6105; 9502.0425, subparts 4, 16, 17; 9503.0155,

subpart 8; 9505.0370; 9505.0371; 9505.0372; 9520.0010; 9520.0020; 9520.0030; 9520.0040; 9520.0050; 9520.0060; 9520.0070; 9520.0080; 9520.0090; 9520.0100; 9520.0110; 9520.0120; 9520.0130; 9520.0140; 9520.0150; 9520.0160; 9520.0170; 9520.0180; 9520.0190; 9520.0200; 9520.0210; 9520.0230; 9549.0057; 9549.0060, subparts 4, 5, 6, 7, 10, 11, 14.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

ARTICLE 1
CHILDREN AND FAMILIES SERVICES

Section 1. Minnesota Statutes 2018, section 119B.011, is amended by adding a subdivision to read:

Subd. 13b. **Homeless.** "Homeless" means a self-declared housing status as defined in the McKinney-Vento Homeless Assistance Act and United States Code, title 42, section 11302, paragraph (a).

EFFECTIVE DATE. This section is effective September 21, 2020.

Sec. 2. Minnesota Statutes 2018, section 119B.011, subdivision 19, is amended to read:

Subd. 19. **Provider.** "Provider" means:

(1) an individual or child care center or facility~~, either licensed or unlicensed, providing legal child care services as defined~~ licensed to provide child care under ~~section 245A.03~~ chapter 245A when operating within the terms of the license; ~~or~~

(2) a license exempt center required to be certified under chapter 245H;

(3) an individual or child care center or facility ~~holding~~ that: (i) holds a valid child care license issued by another state or a tribe ~~and providing~~; (ii) provides child care services in the licensing state or in the area under the licensing tribe's jurisdiction; and (iii) is in compliance with federal health and safety requirements as certified by the licensing state or tribe, or as determined by receipt of child care development block grant funds in the licensing state; or

(4) a legal nonlicensed child care provider as defined under section 119B.011, subdivision 16, providing legal child care services. A ~~legally unlicensed family~~ legal nonlicensed child care provider must be at least 18 years of age, and not a member of the MFIP assistance unit or a member of the family receiving child care assistance to be authorized under this chapter.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 3. Minnesota Statutes 2018, section 119B.011, subdivision 20, is amended to read:

Subd. 20. **Transition year families.** "Transition year families" means families who have received MFIP assistance, or who were eligible to receive MFIP assistance after choosing to discontinue receipt of the cash portion of MFIP assistance under section 256J.31, subdivision 12, or families who have received DWP assistance under section 256J.95 for at least ~~three~~ one of the last six months before losing eligibility for MFIP or DWP. Notwithstanding Minnesota Rules, parts 3400.0040, subpart 10, and 3400.0090, subpart 2, transition year child care may be used to support employment, approved education or training programs, or job search that meets the requirements of section 119B.10. Transition year child care is not available to families who have been disqualified from MFIP or DWP due to fraud.

EFFECTIVE DATE. This section is effective March 23, 2020.

Sec. 4. Minnesota Statutes 2018, section 119B.02, subdivision 7, is amended to read:

Subd. 7. **Child care market rate survey.** ~~Biennially,~~ The commissioner shall conduct the next survey of prices charged by child care providers in Minnesota in state fiscal year 2021 and every three years thereafter to determine the 75th percentile for like-care arrangements in county price clusters.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 5. Minnesota Statutes 2018, section 119B.025, subdivision 1, is amended to read:

Subdivision 1. **Applications.** (a) Except as provided in paragraph (c), clause (4), the county shall verify the following at all initial child care applications using the universal application:

(1) identity of adults;

(2) presence of the minor child in the home, if questionable;

(3) relationship of minor child to the parent, stepparent, legal guardian, eligible relative caretaker, or the spouses of any of the foregoing;

(4) age;

(5) immigration status, if related to eligibility;

(6) Social Security number, if given;

(7) counted income;

(8) spousal support and child support payments made to persons outside the household;

(9) residence; and

(10) inconsistent information, if related to eligibility.

(b) The county must mail a notice of approval or denial of assistance to the applicant within 30 calendar days after receiving the application. The county may extend the response time by 15 calendar days if the applicant is informed of the extension.

(c) For an applicant who declares that the applicant is homeless and who meets the definition of homeless in section 119B.011, subdivision 13b, the county must:

(1) if information is needed to determine eligibility, send a request for information to the applicant within five working days after receiving the application;

(2) if the applicant is eligible, send a notice of approval of assistance within five working days after receiving the application;

(3) if the applicant is ineligible, send a notice of denial of assistance within 30 days after receiving the application. The county may extend the response time by 15 calendar days if the applicant is informed of the extension;

(4) not require verifications required by paragraph (a) before issuing the notice of approval or denial; and

(5) follow limits set by the commissioner for how frequently expedited application processing may be used for an applicant under this paragraph.

(d) An applicant who declares that the applicant is homeless must submit proof of eligibility within three months of the date the application was received. If proof of eligibility is not submitted within three months, eligibility ends. A 15-day adverse action notice is required to end eligibility.

EFFECTIVE DATE. This section is effective September 21, 2020.

Sec. 6. Minnesota Statutes 2018, section 119B.03, subdivision 9, is amended to read:

Subd. 9. **Portability pool.** (a) The commissioner shall establish a pool of up to five percent of the annual appropriation for the basic sliding fee program to provide continuous child care assistance for eligible families who move between Minnesota counties. At the end of each allocation period, any unspent funds in the portability pool must be used for assistance under the basic sliding fee program. If expenditures from the portability pool

exceed the amount of money available, the reallocation pool must be reduced to cover these shortages.

(b) ~~To be eligible for portable basic sliding fee assistance,~~ A family that has moved from a county in which it was receiving basic sliding fee assistance to a county with a waiting list for the basic sliding fee program must:

(1) meet the income and eligibility guidelines for the basic sliding fee program; and

(2) notify ~~the new county of residence within 60 days of moving and submit information to the new county of residence to verify eligibility for the basic sliding fee program~~ the family's previous county of residence of the family's move to a new county of residence.

(c) The receiving county must:

(1) accept administrative responsibility for applicants for portable basic sliding fee assistance at the end of the two months of assistance under the Unitary Residency Act;

(2) continue portability pool basic sliding fee assistance ~~for the lesser of six months or~~ until the family is able to receive assistance under the county's regular basic sliding program; and

(3) notify the commissioner through the quarterly reporting process of any family that meets the criteria of the portable basic sliding fee assistance pool.

EFFECTIVE DATE. This section is effective December 2, 2019.

Sec. 7. Minnesota Statutes 2018, section 119B.09, subdivision 1, is amended to read:

Subdivision 1. **General eligibility requirements.** (a) Child care services must be available to families who need child care to find or keep employment or to obtain the training or education necessary to find employment and who:

(1) have household income less than or equal to 67 percent of the state median income, adjusted for family size, at application and redetermination, and meet the requirements of section 119B.05; receive MFIP assistance; and are participating in employment and training services under chapter 256J; or

(2) have household income less than or equal to 47 percent of the state median income, adjusted for family size, at application and less than or equal to 67 percent of the state median income, adjusted for family size, at redetermination.

(b) Child care services must be made available as in-kind services.

(c) All applicants for child care assistance and families currently receiving child care assistance must be assisted and required to cooperate in establishment of paternity and enforcement of child support obligations for all children in the family at application and redetermination as a condition of program eligibility. For purposes of this section, a family is considered to meet the requirement for cooperation when the family complies with the requirements of section 256.741.

(d) All applicants for child care assistance and families currently receiving child care assistance must pay the co-payment fee under section 119B.12, subdivision 2, as a condition of eligibility. The co-payment fee may include additional recoupment fees due to a child care assistance program overpayment.

(e) If a family has one child with a child care authorization and the child reaches 13 years of age or the child has a disability and reaches 15 years of age, the family remains eligible until the redetermination.

EFFECTIVE DATE. This section is effective June 29, 2020.

Sec. 8. Minnesota Statutes 2018, section 119B.09, subdivision 7, is amended to read:

Subd. 7. **Date of eligibility for assistance.** (a) The date of eligibility for child care assistance under this chapter is the later of the date the application was received by the county; the beginning date of employment, education, or training; the date the infant is born for applicants to the at-home infant care program; or the date a determination has been made that the applicant is a participant in employment and training services under Minnesota Rules, part 3400.0080, or chapter 256J.

(b) Payment ceases for a family under the at-home infant child care program when a family has used a total of 12 months of assistance as specified under section 119B.035. Payment of child care assistance for employed persons on MFIP is effective the date of employment or the date of MFIP eligibility, whichever is later. Payment of child care assistance for MFIP or DWP participants in employment and training services is effective the date of commencement of the services or the date of MFIP or DWP eligibility, whichever is later. Payment of child care assistance for transition year child care must be made retroactive to the date of eligibility for transition year child care.

(c) Notwithstanding paragraph (b), payment of child care assistance for participants eligible under section 119B.05 may only be made retroactive for a maximum of ~~six~~ three months from the date of application for child care assistance.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 9. Minnesota Statutes 2018, section 119B.095, subdivision 2, is amended to read:

Subd. 2. **Maintain steady child care authorizations.** (a) Notwithstanding Minnesota Rules, chapter 3400, the amount of child care authorized under section 119B.10 for employment, education, or an MFIP or DWP employment plan shall continue at the same number of hours or more hours until redetermination, including:

(1) when the other parent moves in and is employed or has an education plan under section 119B.10, subdivision 3, or has an MFIP or DWP employment plan; or

(2) when the participant's work hours are reduced or a participant temporarily stops working or attending an approved education program. Temporary changes include, but are not limited to, a medical leave, seasonal employment fluctuations, or a school break between semesters.

(b) The county may increase the amount of child care authorized at any time if the participant verifies the need for increased hours for authorized activities.

(c) The county may reduce the amount of child care authorized if a parent requests a reduction or because of a change in:

(1) the child's school schedule;

(2) the custody schedule; or

(3) the provider's availability.

(d) The amount of child care authorized for a family subject to subdivision 1, paragraph (b), must change when the participant's activity schedule changes. Paragraph (a) does not apply to a family subject to subdivision 1, paragraph (b).

(e) When a child reaches 13 years of age or a child with a disability reaches 15 years of age, the amount of child care authorized shall continue at the same number of hours or more hours until redetermination.

EFFECTIVE DATE. This section is effective June 29, 2020.

Sec. 10. Minnesota Statutes 2018, section 119B.095, is amended by adding a subdivision to read:

Subd. 3. **Assistance for persons who are homeless.** An applicant who is homeless and eligible for child care assistance is exempt from the activity participation requirements under this chapter for three months. The applicant under this subdivision is eligible for 60 hours of child care assistance per service period for three months from the date the county receives

the application. Additional hours may be authorized as needed based on the applicant's participation in employment, education, or MFIP or DWP employment plan. To continue receiving child care assistance after the initial three months, the applicant must verify that the applicant meets eligibility and activity requirements for child care assistance under this chapter.

EFFECTIVE DATE. This section is effective September 21, 2020.

Sec. 11. Minnesota Statutes 2018, section 119B.125, subdivision 6, is amended to read:

Subd. 6. **Record-keeping requirement.** (a) As a condition of payment, all providers receiving child care assistance payments must:

(1) keep accurate and legible daily attendance records at the site where services are delivered for children receiving child care assistance; and

~~must~~ (2) make those records available immediately to the county or the commissioner upon request. Any records not provided to a county or the commissioner at the date and time of the request are deemed inadmissible if offered as evidence by the provider in any proceeding to contest an overpayment or disqualification of the provider.

~~The~~ (b) As a condition of payment, attendance records must be completed daily and include the date, the first and last name of each child in attendance, and the times when each child is dropped off and picked up. To the extent possible, the times that the child was dropped off to and picked up from the child care provider must be entered by the person dropping off or picking up the child. The daily attendance records must be retained at the site where services are delivered for six years after the date of service.

(c) A county or the commissioner may deny or revoke a provider's authorization ~~as a child care provider to any applicant, rescind authorization of any provider,~~ to receive child care assistance payments under section 119B.13, subdivision 6, paragraph (d), pursue a fraud disqualification under section 256.98, take an action against the provider under chapter 245E, or establish an attendance record overpayment ~~claim in the system~~ under paragraph (d) against a current or former provider, when the county or the commissioner knows or has reason to believe that the provider has not complied with the record-keeping requirement in this subdivision. ~~A provider's failure to produce attendance records as requested on more than one occasion constitutes grounds for disqualification as a provider.~~

(d) To calculate an attendance record overpayment under this subdivision, the commissioner or county agency shall subtract the maximum daily rate from the total amount

paid to a provider for each day that a child's attendance record is missing, unavailable, incomplete, illegible, inaccurate, or otherwise inadequate.

(e) The commissioner shall develop criteria for a county to determine an attendance record overpayment under this subdivision.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 12. Minnesota Statutes 2018, section 119B.13, subdivision 1, is amended to read:

Subdivision 1. **Subsidy restrictions.** (a) ~~Beginning February 3, 2014,~~ The maximum rate paid for child care assistance in any county or county price cluster under the child care fund shall be the greater of the 25th percentile of the ~~2011~~ most recent child care provider rate survey under section 119B.02, subdivision 7, or the ~~maximum rate effective November 28, 2011~~ rates in effect at the time of the update. The first maximum rate update must be based on the 2018 rate survey and take effect September 20, 2019. Thereafter, maximum rate updates are effective the first biweekly period following September 1 after the most recent rate survey. For a child care provider located within the boundaries of a city located in two or more of the counties of Benton, Sherburne, and Stearns, the maximum rate paid for child care assistance shall be equal to the maximum rate paid in the county with the highest maximum reimbursement rates or the provider's charge, whichever is less. The commissioner may: (1) assign a county with no reported provider prices to a similar price cluster; and (2) consider county level access when determining final price clusters.

(b) A rate which includes a special needs rate paid under subdivision 3 may be in excess of the maximum rate allowed under this subdivision.

(c) The department shall monitor the effect of this paragraph on provider rates. The county shall pay the provider's full charges for every child in care up to the maximum established. The commissioner shall determine the maximum rate for each type of care on an hourly, full-day, and weekly basis, including special needs and disability care.

(d) If a child uses one provider, the maximum payment for one day of care must not exceed the daily rate. The maximum payment for one week of care must not exceed the weekly rate.

(e) If a child uses two providers under section 119B.097, the maximum payment must not exceed:

(1) the daily rate for one day of care;

(2) the weekly rate for one week of care by the child's primary provider; and

(3) two daily rates during two weeks of care by a child's secondary provider.

(f) Child care providers receiving reimbursement under this chapter must not be paid activity fees or an additional amount above the maximum rates for care provided during nonstandard hours for families receiving assistance.

(g) If the provider charge is greater than the maximum provider rate allowed, the parent is responsible for payment of the difference in the rates in addition to any family co-payment fee.

(h) All maximum provider rates changes shall be implemented on the Monday following the effective date of the maximum provider rate.

(i) ~~Notwithstanding Minnesota Rules, part 3400.0130, subpart 7, maximum registration fees in effect on January 1, 2013, shall remain in effect.~~ The maximum registration fee paid for child care assistance in any county or county price cluster under the child care fund shall be the greater of the 25th percentile of the most recent child care provider rate survey under section 119B.02, subdivision 7, or the registration fee in effect at the time of the update. The first maximum registration fee update must be based on the 2018 rate survey and is effective September 23, 2019. Thereafter, maximum registration fee updates are effective the first biweekly period following September 1 after the most recent rate survey. Maximum registration fees must be set for licensed family child care and for child care centers. For a child care provider located within the boundaries of a city located in two or more of the counties of Benton, Sherburne, and Stearns, the maximum registration fee paid for child care assistance shall be equal to the maximum registration fee paid in the county with the highest maximum registration fee or the provider's charge, whichever is less.

EFFECTIVE DATE. Paragraph (a) is effective September 20, 2019. Paragraph (i) is effective September 23, 2019.

Sec. 13. Minnesota Statutes 2018, section 119B.13, subdivision 6, is amended to read:

Subd. 6. **Provider payments.** (a) A provider shall bill only for services documented according to section 119B.125, subdivision 6. The provider shall bill for services provided within ten days of the end of the service period. Payments under the child care fund shall be made within 21 days of receiving a complete bill from the provider. Counties or the state may establish policies that make payments on a more frequent basis.

(b) If a provider has received an authorization of care and been issued a billing form for an eligible family, the bill must be submitted within 60 days of the last date of service on the bill. A bill submitted more than 60 days after the last date of service must be paid if the

county determines that the provider has shown good cause why the bill was not submitted within 60 days. Good cause must be defined in the county's child care fund plan under section 119B.08, subdivision 3, and the definition of good cause must include county error. Any bill submitted more than a year after the last date of service on the bill must not be paid.

(c) If a provider provided care for a time period without receiving an authorization of care and a billing form for an eligible family, payment of child care assistance may only be made retroactively for a maximum of six months from the date the provider is issued an authorization of care and billing form.

(d) A county or the commissioner may refuse to issue a child care authorization to a licensed or legal nonlicensed provider, revoke an existing child care authorization to a licensed or legal nonlicensed provider, stop payment issued to a licensed or legal nonlicensed provider, or refuse to pay a bill submitted by a licensed or legal nonlicensed provider if:

(1) the provider admits to intentionally giving the county materially false information on the provider's billing forms;

(2) a county or the commissioner finds by a preponderance of the evidence that the provider intentionally gave the county materially false information on the provider's billing forms, or provided false attendance records to a county or the commissioner;

(3) the provider is in violation of child care assistance program rules, until the agency determines those violations have been corrected;

(4) the provider is operating after:

(i) an order of suspension of the provider's license issued by the commissioner;

(ii) an order of revocation of the provider's license; or

(iii) a final order of conditional license issued by the commissioner for as long as the conditional license is in effect;

(5) the provider submits false attendance reports or refuses to provide documentation of the child's attendance upon request; ~~or~~

(6) the provider gives false child care price information~~.~~; or

(7) the provider fails to report decreases in a child's attendance, as required under section 119B.125, subdivision 9.

(e) For purposes of paragraph (d), clauses (3), (5), ~~and~~ (6), and (7), the county or the commissioner may withhold the provider's authorization or payment for a period of time not to exceed three months beyond the time the condition has been corrected.

(f) A county's payment policies must be included in the county's child care plan under section 119B.08, subdivision 3. If payments are made by the state, in addition to being in compliance with this subdivision, the payments must be made in compliance with section 16A.124.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 14. Minnesota Statutes 2018, section 119B.13, subdivision 7, is amended to read:

Subd. 7. **Absent days.** (a) Licensed child care providers and license-exempt centers must not be reimbursed for more than 25 full-day absent days per child, excluding holidays, in a ~~fiscal~~ calendar year, or for more than ten consecutive full-day absent days. "Absent day" means any day that the child is authorized and scheduled to be in care with a licensed provider or license exempt center, and the child is absent from the care for the entire day. Legal nonlicensed family child care providers must not be reimbursed for absent days. If a child attends for part of the time authorized to be in care in a day, but is absent for part of the time authorized to be in care in that same day, the absent time must be reimbursed but the time must not count toward the absent days limit. Child care providers must only be reimbursed for absent days if the provider has a written policy for child absences and charges all other families in care for similar absences.

(b) Notwithstanding paragraph (a), children with documented medical conditions that cause more frequent absences may exceed the 25 absent days limit, or ten consecutive full-day absent days limit. Absences due to a documented medical condition of a parent or sibling who lives in the same residence as the child receiving child care assistance do not count against the absent days limit in a ~~fiscal~~ calendar year. Documentation of medical conditions must be on the forms and submitted according to the timelines established by the commissioner. A public health nurse or school nurse may verify the illness in lieu of a medical practitioner. If a provider sends a child home early due to a medical reason, including, but not limited to, fever or contagious illness, the child care center director or lead teacher may verify the illness in lieu of a medical practitioner.

(c) Notwithstanding paragraph (a), children in families may exceed the absent days limit if at least one parent: (1) is under the age of 21; (2) does not have a high school diploma or commissioner of education-selected high school equivalency certification; and (3) is a student in a school district or another similar program that provides or arranges for child

care, parenting support, social services, career and employment supports, and academic support to achieve high school graduation, upon request of the program and approval of the county. If a child attends part of an authorized day, payment to the provider must be for the full amount of care authorized for that day.

(d) Child care providers must be reimbursed for up to ten federal or state holidays or designated holidays per year when the provider charges all families for these days and the holiday or designated holiday falls on a day when the child is authorized to be in attendance. Parents may substitute other cultural or religious holidays for the ten recognized state and federal holidays. Holidays do not count toward the absent days limit.

(e) A family or child care provider must not be assessed an overpayment for an absent day payment unless (1) there was an error in the amount of care authorized for the family, (2) all of the allowed full-day absent payments for the child have been paid, or (3) the family or provider did not timely report a change as required under law.

(f) The provider and family shall receive notification of the number of absent days used upon initial provider authorization for a family and ongoing notification of the number of absent days used as of the date of the notification.

(g) For purposes of this subdivision, "absent days limit" means 25 full-day absent days per child, excluding holidays, in a ~~fiscal~~ calendar year; and ten consecutive full-day absent days.

(h) For purposes of this subdivision, "holidays limit" means ten full-day holidays per child, excluding absent days, in a calendar year.

(i) If a day meets the criteria of an absent day or a holiday under this subdivision, the provider must bill that day as an absent day or holiday. A provider's failure to properly bill an absent day or a holiday results in an overpayment, regardless of whether the child reached, or is exempt from, the absent days limit or holidays limit for the calendar year.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 15. Minnesota Statutes 2018, section 119B.16, subdivision 1, is amended to read:

Subdivision 1. **Fair hearing allowed for applicants and recipients.** (a) An applicant or recipient adversely affected by an action of a county agency ~~action~~ or the commissioner, for an action taken directly against the applicant or recipient, may request and receive a fair hearing in accordance with this subdivision and section 256.045. An applicant or recipient does not have a right to a fair hearing if a county agency or the commissioner takes action against a provider.

(b) A county agency must offer an informal conference to an applicant or recipient who is entitled to a fair hearing under this section. A county agency must advise an applicant or recipient that a request for a conference is optional and does not delay or replace the right to a fair hearing.

(c) If a provider's authorization is suspended, denied, or revoked, a county agency or the commissioner must mail notice to each child care assistance program recipient receiving care from the provider.

EFFECTIVE DATE. This section is effective February 26, 2021.

Sec. 16. Minnesota Statutes 2018, section 119B.16, subdivision 1a, is amended to read:

Subd. 1a. **Fair hearing allowed for providers.** (a) This subdivision applies to providers caring for children receiving child care assistance.

~~(b) A provider to whom a county agency has assigned responsibility for an overpayment may request a fair hearing in accordance with section 256.045 for the limited purpose of challenging the assignment of responsibility for the overpayment and the amount of the overpayment. The scope of the fair hearing does not include the issues of whether the provider wrongfully obtained public assistance in violation of section 256.98 or was properly disqualified under section 256.98, subdivision 8, paragraph (c), unless the fair hearing has been combined with an administrative disqualification hearing brought against the provider under section 256.046.~~

(b) A provider may request a fair hearing according to sections 256.045 and 256.046 only if a county agency or the commissioner:

(1) denies or revokes a provider's authorization, unless the action entitles the provider to an administrative review under section 119B.161;

(2) assigns responsibility for an overpayment to a provider under section 119B.11, subdivision 2a;

(3) establishes an overpayment for failure to comply with section 119B.125, subdivision 6;

(4) seeks monetary recovery or recoupment under section 245E.02, subdivision 4, paragraph (c), clause (2);

(5) initiates an administrative fraud disqualification hearing; or

(6) issues a payment and the provider disagrees with the amount of the payment.

(c) A provider may request a fair hearing by submitting a written request to the Department of Human Services, Appeals Division. A provider's request must be received by the Appeals Division no later than 30 days after the date a county or the commissioner mails the notice.

(d) The provider's appeal request must contain the following:

(1) each disputed item, the reason for the dispute, and, if applicable, an estimate of the dollar amount involved for each disputed item;

(2) the computation the provider believes to be correct, if applicable;

(3) the statute or rule relied on for each disputed item; and

(4) the name, address, and telephone number of the person at the provider's place of business with whom contact may be made regarding the appeal.

EFFECTIVE DATE. This section is effective February 26, 2021.

Sec. 17. Minnesota Statutes 2018, section 119B.16, subdivision 1b, is amended to read:

Subd. 1b. **Joint fair hearings.** ~~When a provider requests a fair hearing under subdivision 1a, the family in whose case the overpayment was created must be made a party to the fair hearing. All other issues raised by the family must be resolved in the same proceeding. When a family requests a fair hearing and claims that the county should have assigned responsibility for an overpayment to a provider, the provider must be made a party to the fair hearing.~~ The human services judge assigned to a fair hearing may join a family or a provider as a party to the fair hearing whenever joinder of that party is necessary to fully and fairly resolve ~~overpayment~~ issues raised in the appeal.

EFFECTIVE DATE. This section is effective February 26, 2021.

Sec. 18. Minnesota Statutes 2018, section 119B.16, is amended by adding a subdivision to read:

Subd. 1c. **Notice to providers.** (a) Before taking an action appealable under subdivision 1a, paragraph (b), a county agency or the commissioner must mail written notice to the provider against whom the action is being taken. Unless otherwise specified under chapter 119B or 245E or Minnesota Rules, chapter 3400, a county agency or the commissioner must mail the written notice at least 15 calendar days before the adverse action's effective date.

(b) The notice shall state (1) the factual basis for the department's determination, (2) the action the department intends to take, (3) the dollar amount of the monetary recovery or

recoupment, if known, and (4) the provider's right to appeal the department's proposed action.

EFFECTIVE DATE. This section is effective February 26, 2021.

Sec. 19. Minnesota Statutes 2018, section 119B.16, is amended by adding a subdivision to read:

Subd. 3. **Fair hearing stayed.** (a) If a county agency or the commissioner denies or revokes a provider's authorization based on a licensing action under section 245A.07, and the provider appeals, the provider's fair hearing must be stayed until the commissioner issues an order as required under section 245A.08, subdivision 5.

(b) If the commissioner denies or revokes a provider's authorization based on decertification under section 245H.07, and the provider appeals, the provider's fair hearing must be stayed until the commissioner issues a final order as required under section 245H.07.

EFFECTIVE DATE. This section is effective February 26, 2021.

Sec. 20. Minnesota Statutes 2018, section 119B.16, is amended by adding a subdivision to read:

Subd. 4. **Final department action.** Unless the commissioner receives a timely and proper request for an appeal, a county agency's or the commissioner's action shall be considered a final department action.

EFFECTIVE DATE. This section is effective February 26, 2021.

Sec. 21. **[119B.161] ADMINISTRATIVE REVIEW.**

Subdivision 1. **Applicability.** A provider has the right to an administrative review under this section if (1) a payment was suspended under chapter 245E, or (2) the provider's authorization was denied or revoked under section 119B.13, subdivision 6, paragraph (d), clause (1) or (2).

Subd. 2. **Notice.** (a) A county agency or the commissioner must mail written notice to a provider within five days of suspending payment or denying or revoking the provider's authorization under subdivision 1.

(b) The notice must:

(1) state the provision under which a county agency or the commissioner is denying, revoking, or suspending the provider's authorization or suspending payment to the provider;

(2) set forth the general allegations leading to the denial, revocation, or suspension of the provider's authorization. The notice need not disclose any specific information concerning an ongoing investigation;

(3) state that the denial, revocation, or suspension of the provider's authorization is for a temporary period and explain the circumstances under which the action expires; and

(4) inform the provider of the right to submit written evidence and argument for consideration by the commissioner.

(c) Notwithstanding Minnesota Rules, part 3400.0185, if a county agency or the commissioner suspends payment to a provider under chapter 245E or denies or revokes a provider's authorization under section 119B.13, subdivision 6, paragraph (d), clause (1) or (2), a county agency or the commissioner must send notice of service authorization closure to each affected family. The notice sent to an affected family is effective on the date the notice is created.

Subd. 3. **Duration.** If a provider's payment is suspended under chapter 245E or a provider's authorization is denied or revoked under section 119B.13, subdivision 6, paragraph (d), clause (1) or (2), the provider's denial, revocation, temporary suspension, or payment suspension remains in effect until:

(1) the commissioner or a law enforcement authority determines that there is insufficient evidence warranting the action and a county agency or the commissioner does not pursue an additional administrative remedy under chapter 245E or section 256.98; or

(2) all criminal, civil, and administrative proceedings related to the provider's alleged misconduct conclude and any appeal rights are exhausted.

Subd. 4. **Good cause exception.** The commissioner may find that good cause exists not to deny, revoke, or suspend a provider's authorization, or not to continue a denial, revocation, or suspension of a provider's authorization if any of the following are applicable:

(1) a law enforcement authority specifically requested that a provider's authorization not be denied, revoked, or suspended because that action may compromise an ongoing investigation;

(2) the commissioner determines that the denial, revocation, or suspension should be removed based on the provider's written submission; or

(3) the commissioner determines that the denial, revocation, or suspension is not in the best interests of the program.

EFFECTIVE DATE. This section is effective February 26, 2021.

Sec. 22. Minnesota Statutes 2018, section 245A.04, is amended by adding a subdivision to read:

Subd. 9a. **Child foster home variances for capacity.** (a) The commissioner, or the commissioner of corrections under section 241.021, may grant a variance for a licensed family foster parent to allow additional foster children if:

(1) the variance is needed to allow: (i) a parenting youth in foster care to remain with the child of the parenting youth; (ii) siblings to remain together; (iii) a child with an established meaningful relationship with the family to remain with the family; or (iv) a family with special training or skills to provide care to a child who has a severe disability;

(2) there is no risk of harm to a child currently in the home;

(3) the structural characteristics of the home, including sleeping space, accommodates additional foster children;

(4) the home remains in compliance with applicable zoning, health, fire, and building codes; and

(5) the statement of intended use specifies conditions for an exception to capacity limits and specifies how the license holder will maintain a ratio of adults to children that ensures the safety and appropriate supervision of all the children in the home.

(b) A variance granted to a family foster home under Minnesota Rules, part 2960.3030, subpart 3, prior to October 1, 2019, remains in effect until January 1, 2020.

Sec. 23. Minnesota Statutes 2018, section 245C.02, is amended by adding a subdivision to read:

Subd. 6b. **Children's residential facility.** "Children's residential facility" means a children's residential facility licensed by the commissioner of corrections or the commissioner of human services under Minnesota Rules, chapter 2960.

EFFECTIVE DATE. This section is effective July 1, 2019, for background studies initiated on or after that date.

Sec. 24. Minnesota Statutes 2018, section 245C.05, subdivision 5, is amended to read:

Subd. 5. **Fingerprints and photograph.** (a) Notwithstanding paragraph (b), for background studies conducted by the commissioner for child foster care, children's residential

facilities, adoptions, or a transfer of permanent legal and physical custody of a child, the subject of the background study, who is 18 years of age or older, shall provide the commissioner with a set of classifiable fingerprints obtained from an authorized agency for a national criminal history record check.

(b) For background studies initiated on or after the implementation of NETStudy 2.0, except as provided under subdivision 5a, every subject of a background study must provide the commissioner with a set of the background study subject's classifiable fingerprints and photograph. The photograph and fingerprints must be recorded at the same time by the commissioner's authorized fingerprint collection vendor and sent to the commissioner through the commissioner's secure data system described in section 245C.32, subdivision 1a, paragraph (b).

(c) The fingerprints shall be submitted by the commissioner to the Bureau of Criminal Apprehension and, when specifically required by law, submitted to the Federal Bureau of Investigation for a national criminal history record check.

(d) The fingerprints must not be retained by the Department of Public Safety, Bureau of Criminal Apprehension, or the commissioner. The Federal Bureau of Investigation will only retain fingerprints of subjects with a criminal history.

(e) The commissioner's authorized fingerprint collection vendor shall, for purposes of verifying the identity of the background study subject, be able to view the identifying information entered into NETStudy 2.0 by the entity that initiated the background study, but shall not retain the subject's fingerprints, photograph, or information from NETStudy 2.0. The authorized fingerprint collection vendor shall retain no more than the name and date and time the subject's fingerprints were recorded and sent, only as necessary for auditing and billing activities.

(f) For any background study conducted under this chapter, the subject shall provide the commissioner with a set of classifiable fingerprints when the commissioner has reasonable cause to require a national criminal history record check as defined in section 245C.02, subdivision 15a.

EFFECTIVE DATE. This section is effective July 1, 2019, for background studies initiated on or after that date.

Sec. 25. Minnesota Statutes 2018, section 245C.08, subdivision 1, is amended to read:

Subdivision 1. **Background studies conducted by Department of Human Services.** (a) For a background study conducted by the Department of Human Services, the commissioner shall review:

(1) information related to names of substantiated perpetrators of maltreatment of vulnerable adults that has been received by the commissioner as required under section 626.557, subdivision 9c, paragraph (j);

(2) the commissioner's records relating to the maltreatment of minors in licensed programs, and from findings of maltreatment of minors as indicated through the social service information system;

(3) information from juvenile courts as required in subdivision 4 for individuals listed in section 245C.03, subdivision 1, paragraph (a), when there is reasonable cause;

(4) information from the Bureau of Criminal Apprehension, including information regarding a background study subject's registration in Minnesota as a predatory offender under section 243.166;

(5) except as provided in clause (6), information received as a result of submission of fingerprints for a national criminal history record check, as defined in section 245C.02, subdivision 13c, when the commissioner has reasonable cause for a national criminal history record check as defined under section 245C.02, subdivision 15a, or as required under section 144.057, subdivision 1, clause (2);

(6) for a background study related to a child foster care application for licensure, children's residential facilities, a transfer of permanent legal and physical custody of a child under sections 260C.503 to 260C.515, or adoptions, and for a background study required for family child care, certified license-exempt child care, child care centers, and legal nonlicensed child care authorized under chapter 119B, the commissioner shall also review:

(i) information from the child abuse and neglect registry for any state in which the background study subject has resided for the past five years; and

(ii) when the background study subject is 18 years of age or older, or a minor under section 245C.05, subdivision 5a, paragraph (c), information received following submission of fingerprints for a national criminal history record check; and

(7) for a background study required for family child care, certified license-exempt child care centers, licensed child care centers, and legal nonlicensed child care authorized under

chapter 119B, the background study shall also include, to the extent practicable, a name and date-of-birth search of the National Sex Offender Public website.

(b) Notwithstanding expungement by a court, the commissioner may consider information obtained under paragraph (a), clauses (3) and (4), unless the commissioner received notice of the petition for expungement and the court order for expungement is directed specifically to the commissioner.

(c) The commissioner shall also review criminal case information received according to section 245C.04, subdivision 4a, from the Minnesota court information system that relates to individuals who have already been studied under this chapter and who remain affiliated with the agency that initiated the background study.

(d) When the commissioner has reasonable cause to believe that the identity of a background study subject is uncertain, the commissioner may require the subject to provide a set of classifiable fingerprints for purposes of completing a fingerprint-based record check with the Bureau of Criminal Apprehension. Fingerprints collected under this paragraph shall not be saved by the commissioner after they have been used to verify the identity of the background study subject against the particular criminal record in question.

(e) The commissioner may inform the entity that initiated a background study under NETStudy 2.0 of the status of processing of the subject's fingerprints.

EFFECTIVE DATE. This section is effective July 1, 2019, for background studies initiated on or after that date.

Sec. 26. Minnesota Statutes 2018, section 245C.10, is amended by adding a subdivision to read:

Subd. 14. **Children's residential facilities.** The commissioner shall recover the cost of background studies initiated by a licensed children's residential facility through a fee of no more than $51 per study. Fees collected under this subdivision are appropriated to the commissioner for purposes of conducting background studies.

EFFECTIVE DATE. This section is effective July 1, 2019, for background studies initiated on or after that date.

Sec. 27. Minnesota Statutes 2018, section 245C.24, is amended by adding a subdivision to read:

Subd. 5. **Five-year bar to set aside disqualification; children's residential facilities.** The commissioner shall not set aside the disqualification of an individual in

connection with a license for a children's residential facility who was convicted of a felony within the past five years for: (1) physical assault or battery; or (2) a drug-related offense.

EFFECTIVE DATE. This section is effective for background studies initiated on or after July 1, 2019.

Sec. 28. Minnesota Statutes 2018, section 245E.06, subdivision 3, is amended to read:

Subd. 3. **Appeal of department ~~sanction~~ action.** ~~(a) If the department does not pursue a criminal action against a provider, license holder, controlling individual, or recipient for financial misconduct, but the department imposes an administrative sanction under section 245E.02, subdivision 4, paragraph (c), any individual or entity against whom the sanction was imposed may appeal the department's administrative sanction under this section pursuant to section 119B.16 or 256.045 with the additional requirements in clauses (1) to (4). An appeal must specify:~~

~~(1) each disputed item, the reason for the dispute, and an estimate of the dollar amount involved for each disputed item, if appropriate;~~

~~(2) the computation that is believed to be correct, if appropriate;~~

~~(3) the authority in the statute or rule relied upon for each disputed item; and~~

~~(4) the name, address, and phone number of the person at the provider's place of business with whom contact may be made regarding the appeal.~~

~~(b) Notwithstanding section 245E.03, subdivision 4, an appeal is considered timely only if postmarked or received by the department's Appeals Division within 30 days after receiving a notice of department sanction.~~

~~(c) Before the appeal hearing, the department may deny or terminate authorizations or payment to the entity or individual if the department determines that the action is necessary to protect the public welfare or the interests of the child care assistance program.~~

A provider's rights related to the department's action taken under this chapter against a provider are established in sections 119B.16 and 119B.161.

EFFECTIVE DATE. This section is effective February 26, 2021.

Sec. 29. Minnesota Statutes 2018, section 245H.07, is amended to read:

245H.07 DECERTIFICATION.

Subdivision 1. **Generally.** (a) The commissioner may decertify a center if a certification holder:

(1) failed to comply with an applicable law or rule; ~~or~~

(2) knowingly withheld relevant information from or gave false or misleading information to the commissioner in connection with an application for certification, in connection with the background study status of an individual, during an investigation, or regarding compliance with applicable laws or rules~~.~~; or

(3) has authorization to receive child care assistance payments revoked pursuant to chapter 119B.

(b) When considering decertification, the commissioner shall consider the nature, chronicity, or severity of the violation of law or rule.

(c) When a center is decertified, the center is ineligible to receive a child care assistance payment under chapter 119B.

Subd. 2. **Reconsideration.** (a) The certification holder may request reconsideration of the decertification by notifying the commissioner by certified mail or personal service. The request must be made in writing. If sent by certified mail, the request must be postmarked and sent to the commissioner within ten calendar days after the certification holder received the order. If a request is made by personal service, it must be received by the commissioner within ten calendar days after the certification holder received the order. The certification holder may submit with the request for reconsideration written argument or evidence in support of the request for reconsideration.

(b) If the commissioner decertifies a center pursuant to subdivision 1, paragraph (a), clause (3), and if the center appeals the revocation of the center's authorization to receive child care assistance payments, the final decertification determination is stayed until the appeal of the center's authorization under chapter 119B is resolved. If the center also requests reconsideration of the decertification, the center must do so according to paragraph (a). The final decision on reconsideration is stayed until the appeal of the center's authorization under chapter 119B is resolved.

(c) The commissioner's disposition of a request for reconsideration is final and not subject to appeal under chapter 14.

EFFECTIVE DATE. This section is effective February 26, 2021.

Sec. 30. Minnesota Statutes 2018, section 256.01, subdivision 14b, is amended to read:

Subd. 14b. **American Indian child welfare projects.** (a) The commissioner of human services may authorize projects to ~~test~~ initiate tribal delivery of child welfare services to American Indian children and their parents and custodians living on the reservation. The commissioner has authority to solicit and determine which tribes may participate in a project. Grants may be issued to Minnesota Indian tribes to support the projects. The commissioner may waive existing state rules as needed to accomplish the projects. The commissioner may authorize projects to use alternative methods of (1) screening, investigating, and assessing reports of child maltreatment, and (2) administrative reconsideration, administrative appeal, and judicial appeal of maltreatment determinations, provided the alternative methods used by the projects comply with the provisions of sections 256.045 and 626.556 ~~dealing~~ that deal with the rights of individuals who are the subjects of reports or investigations, including notice and appeal rights and data practices requirements. The commissioner shall only authorize alternative methods that comply with the public policy under section 626.556, subdivision 1. The commissioner may seek any federal approvals necessary to carry out the projects as well as seek and use any funds available to the commissioner, including use of federal funds, foundation funds, existing grant funds, and other funds. The commissioner is authorized to advance state funds as necessary to operate the projects. Federal reimbursement applicable to the projects is appropriated to the commissioner for the purposes of the projects. The projects must be required to address responsibility for safety, permanency, and well-being of children.

(b) For the purposes of this section, "American Indian child" means a person under 21 years old and who is a tribal member or eligible for membership in one of the tribes chosen for a project under this subdivision and who is residing on the reservation of that tribe.

(c) In order to qualify for an American Indian child welfare project, a tribe must:

(1) be one of the existing tribes with reservation land in Minnesota;

(2) have a tribal court with jurisdiction over child custody proceedings;

(3) have a substantial number of children for whom determinations of maltreatment have occurred;

(4)(i) have capacity to respond to reports of abuse and neglect under section 626.556; or (ii) have codified the tribe's screening, investigation, and assessment of reports of child

maltreatment procedures, if authorized to use an alternative method by the commissioner under paragraph (a);

(5) provide a wide range of services to families in need of child welfare services; and

(6) have a tribal-state title IV-E agreement in effect.

(d) Grants awarded under this section may be used for the nonfederal costs of providing child welfare services to American Indian children on the tribe's reservation, including costs associated with:

(1) assessment and prevention of child abuse and neglect;

(2) family preservation;

(3) facilitative, supportive, and reunification services;

(4) out-of-home placement for children removed from the home for child protective purposes; and

(5) other activities and services approved by the commissioner that further the goals of providing safety, permanency, and well-being of American Indian children.

(e) When a tribe has initiated a project and has been approved by the commissioner to assume child welfare responsibilities for American Indian children of that tribe under this section, the affected county social service agency is relieved of responsibility for responding to reports of abuse and neglect under section 626.556 for those children during the time within which the tribal project is in effect and funded. The commissioner shall work with tribes and affected counties to develop procedures for data collection, evaluation, and clarification of ongoing role and financial responsibilities of the county and tribe for child welfare services prior to initiation of the project. Children who have not been identified by the tribe as participating in the project shall remain the responsibility of the county. Nothing in this section shall alter responsibilities of the county for law enforcement or court services.

(f) Participating tribes may conduct children's mental health screenings under section 245.4874, subdivision 1, paragraph (a), clause (12), for children who are eligible for the initiative and living on the reservation and who meet one of the following criteria:

(1) the child must be receiving child protective services;

(2) the child must be in foster care; or

(3) the child's parents must have had parental rights suspended or terminated.

Tribes may access reimbursement from available state funds for conducting the screenings. Nothing in this section shall alter responsibilities of the county for providing services under section 245.487.

(g) Participating tribes may establish a local child mortality review panel. In establishing a local child mortality review panel, the tribe agrees to conduct local child mortality reviews for child deaths or near-fatalities occurring on the reservation under subdivision 12. Tribes with established child mortality review panels shall have access to nonpublic data and shall protect nonpublic data under subdivision 12, paragraphs (c) to (e). The tribe shall provide written notice to the commissioner and affected counties when a local child mortality review panel has been established and shall provide data upon request of the commissioner for purposes of sharing nonpublic data with members of the state child mortality review panel in connection to an individual case.

(h) The commissioner shall collect information on outcomes relating to child safety, permanency, and well-being of American Indian children who are served in the projects. Participating tribes must provide information to the state in a format and completeness deemed acceptable by the state to meet state and federal reporting requirements.

(i) In consultation with the White Earth Band, the commissioner shall develop and submit to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services a plan to transfer legal responsibility for providing child protective services to White Earth Band member children residing in Hennepin County to the White Earth Band. The plan shall include a financing proposal, definitions of key terms, statutory amendments required, and other provisions required to implement the plan. The commissioner shall submit the plan by January 15, 2012.

Sec. 31. Minnesota Statutes 2018, section 260C.007, subdivision 18, is amended to read:

Subd. 18. **Foster care.** (a) "Foster care" means ~~24-hour~~ 24-hour substitute care for ~~children placed away from their parents or guardian and~~ a child for whom a responsible social services agency has placement and care responsibility~~. "Foster care" includes, but is not limited to, placement~~ and:

(1) who is placed away from the child's parent or guardian in foster family homes, foster homes of relatives, group homes, emergency shelters, residential facilities not excluded in this subdivision, child care institutions, and preadoptive homes~~.~~; or

(2) who is colocated with the child's parent or guardian in a licensed residential family-based substance abuse disorder treatment program as defined in subdivision 22a; or

(3) who is returned to the care of the child's parent or guardian from whom the child was removed under a trial home visit pursuant to section 260C.201, subdivision 1, paragraph (a), clause (3).

(b) A child is in foster care under this definition regardless of whether the facility is licensed and payments are made for the cost of care. Nothing in this definition creates any authority to place a child in a home or facility that is required to be licensed which is not licensed. "Foster care" does not include placement in any of the following facilities: hospitals, inpatient chemical dependency treatment facilities where the child is the recipient of the treatment, facilities that are primarily for delinquent children, any corrections facility or program within a particular correction's facility not meeting requirements for title IV-E facilities as determined by the commissioner, facilities to which a child is committed under the provision of chapter 253B, forestry camps, or jails. Foster care is intended to provide for a child's safety or to access treatment. Foster care must not be used as a punishment or consequence for a child's behavior.

Sec. 32. Minnesota Statutes 2018, section 260C.007, is amended by adding a subdivision to read:

Subd. 22a. **Licensed residential family-based substance use disorder treatment program.** "Licensed residential family-based substance use disorder treatment program" means a residential treatment facility that provides the parent or guardian with parenting skills training, parent education, or individual and family counseling, under an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma according to recognized principles of a trauma-informed approach and trauma-specific interventions to address the consequences of trauma and facilitate healing.

Sec. 33. Minnesota Statutes 2018, section 260C.178, subdivision 1, is amended to read:

Subdivision 1. **Hearing and release requirements.** (a) If a child was taken into custody under section 260C.175, subdivision 1, clause (1) or (2), item (ii), the court shall hold a hearing within 72 hours of the time the child was taken into custody, excluding Saturdays, Sundays, and holidays, to determine whether the child should continue in custody.

(b) Unless there is reason to believe that the child would endanger self or others or not return for a court hearing, or that the child's health or welfare would be immediately endangered, the child shall be released to the custody of a parent, guardian, custodian, or other suitable person, subject to reasonable conditions of release including, but not limited

to, a requirement that the child undergo a chemical use assessment as provided in section 260C.157, subdivision 1.

(c) If the court determines there is reason to believe that the child would endanger self or others or not return for a court hearing, or that the child's health or welfare would be immediately endangered if returned to the care of the parent or guardian who has custody and from whom the child was removed, the court shall order the child into foster care as defined in section 260C.007, subdivision 18, under the legal responsibility of the responsible social services agency or responsible probation or corrections agency for the purposes of protective care as that term is used in the juvenile court rules or into the home of a noncustodial parent and order the noncustodial parent to comply with any conditions the court determines to be appropriate to the safety and care of the child, including cooperating with paternity establishment proceedings in the case of a man who has not been adjudicated the child's father. The court shall not give the responsible social services legal custody and order a trial home visit at any time prior to adjudication and disposition under section 260C.201, subdivision 1, paragraph (a), clause (3), but may order the child returned to the care of the parent or guardian who has custody and from whom the child was removed and order the parent or guardian to comply with any conditions the court determines to be appropriate to meet the safety, health, and welfare of the child.

(d) In determining whether the child's health or welfare would be immediately endangered, the court shall consider whether the child would reside with a perpetrator of domestic child abuse.

(e) The court, before determining whether a child should be placed in or continue in foster care under the protective care of the responsible agency, shall also make a determination, consistent with section 260.012 as to whether reasonable efforts were made to prevent placement or whether reasonable efforts to prevent placement are not required. In the case of an Indian child, the court shall determine whether active efforts, according to section 260.762 and the Indian Child Welfare Act of 1978, United States Code, title 25, section 1912(d), were made to prevent placement. The court shall enter a finding that the responsible social services agency has made reasonable efforts to prevent placement when the agency establishes either:

(1) that it has actually provided services or made efforts in an attempt to prevent the child's removal but that such services or efforts have not proven sufficient to permit the child to safely remain in the home; or

(2) that there are no services or other efforts that could be made at the time of the hearing that could safely permit the child to remain home or to return home. When reasonable efforts to prevent placement are required and there are services or other efforts that could be ordered which would permit the child to safely return home, the court shall order the child returned to the care of the parent or guardian and the services or efforts put in place to ensure the child's safety. When the court makes a prima facie determination that one of the circumstances under paragraph (g) exists, the court shall determine that reasonable efforts to prevent placement and to return the child to the care of the parent or guardian are not required.

If the court finds the social services agency's preventive or reunification efforts have not been reasonable but further preventive or reunification efforts could not permit the child to safely remain at home, the court may nevertheless authorize or continue the removal of the child.

(f) The court may not order or continue the foster care placement of the child unless the court makes explicit, individualized findings that continued custody of the child by the parent or guardian would be contrary to the welfare of the child and that placement is in the best interest of the child.

(g) At the emergency removal hearing, or at any time during the course of the proceeding, and upon notice and request of the county attorney, the court shall determine whether a petition has been filed stating a prima facie case that:

(1) the parent has subjected a child to egregious harm as defined in section 260C.007, subdivision 14;

(2) the parental rights of the parent to another child have been involuntarily terminated;

(3) the child is an abandoned infant under section 260C.301, subdivision 2, paragraph (a), clause (2);

(4) the parents' custodial rights to another child have been involuntarily transferred to a relative under Minnesota Statutes 2010, section 260C.201, subdivision 11, paragraph (e), clause (1); section 260C.515, subdivision 4; or a similar law of another jurisdiction;

(5) the parent has committed sexual abuse as defined in section 626.556, subdivision 2, against the child or another child of the parent;

(6) the parent has committed an offense that requires registration as a predatory offender under section 243.166, subdivision 1b, paragraph (a) or (b); or

(7) the provision of services or further services for the purpose of reunification is futile and therefore unreasonable.

(h) When a petition to terminate parental rights is required under section 260C.301, subdivision 4, or 260C.503, subdivision 2, but the county attorney has determined not to proceed with a termination of parental rights petition, and has instead filed a petition to transfer permanent legal and physical custody to a relative under section 260C.507, the court shall schedule a permanency hearing within 30 days of the filing of the petition.

(i) If the county attorney has filed a petition under section 260C.307, the court shall schedule a trial under section 260C.163 within 90 days of the filing of the petition except when the county attorney determines that the criminal case shall proceed to trial first under section 260C.503, subdivision 2, paragraph (c).

(j) If the court determines the child should be ordered into foster care and the child's parent refuses to give information to the responsible social services agency regarding the child's father or relatives of the child, the court may order the parent to disclose the names, addresses, telephone numbers, and other identifying information to the responsible social services agency for the purpose of complying with sections 260C.151, 260C.212, 260C.215, and 260C.221.

(k) If a child ordered into foster care has siblings, whether full, half, or step, who are also ordered into foster care, the court shall inquire of the responsible social services agency of the efforts to place the children together as required by section 260C.212, subdivision 2, paragraph (d), if placement together is in each child's best interests, unless a child is in placement for treatment or a child is placed with a previously noncustodial parent who is not a parent to all siblings. If the children are not placed together at the time of the hearing, the court shall inquire at each subsequent hearing of the agency's reasonable efforts to place the siblings together, as required under section 260.012. If any sibling is not placed with another sibling or siblings, the agency must develop a plan to facilitate visitation or ongoing contact among the siblings as required under section 260C.212, subdivision 1, unless it is contrary to the safety or well-being of any of the siblings to do so.

(l) When the court has ordered the child into foster care or into the home of a noncustodial parent, the court may order a chemical dependency evaluation, mental health evaluation, medical examination, and parenting assessment for the parent as necessary to support the development of a plan for reunification required under subdivision 7 and section 260C.212, subdivision 1, or the child protective services plan under section 626.556, subdivision 10, and Minnesota Rules, part 9560.0228.

Sec. 34. **[260C.190] FAMILY-FOCUSED RESIDENTIAL PLACEMENT.**

Subdivision 1. **Placement.** (a) An agency with legal responsibility for a child under section 260C.178, subdivision 1, paragraph (c), or legal custody of a child under section 260C.201, subdivision 1, paragraph (a), clause (3), may colocate a child with a parent who is receiving services in a licensed residential family-based substance use disorder treatment program for up to 12 months.

(b) During the child's placement under paragraph (a), the agency: (1) may visit the child as the agency deems necessary and appropriate; (2) shall continue to have access to information under section 260C.208; and (3) shall continue to provide appropriate services to both the parent and the child.

(c) The agency may terminate the child's placement under paragraph (a) to protect the child's health, safety, or welfare and may remove the child to foster care without a prior court order or authorization.

Subd. 2. **Case plans.** (a) Before a child may be colocated with a parent in a licensed residential family-based substance use disorder treatment program, a recommendation that the child's placement with a parent is in the child's best interests must be documented in the child's case plan. Each child must have a written case plan developed with the parent and the treatment program staff that describes the safety plan for the child and the treatment program's responsibilities if the parent leaves or is discharged without completing the program. The treatment program must be provided with a copy of the case plan that includes the recommendations and safety plan at the time the child is colocated with the parent.

(b) An out-of-home placement plan under section 260C.212, subdivision 1, must be completed no later than 30 days from when a child is colocated with a parent in a licensed residential family-based substance use disorder treatment program. The written plan developed with parent and treatment program staff in paragraph (a) may be updated and must be incorporated into the out-of-home placement plan. The treatment program must be provided with a copy of the child's out-of-home placement plan.

Subd. 3. **Required reviews and permanency proceedings.** (a) For a child colocated with a parent under subdivision 1, court reviews must occur according to section 260C.202.

(b) If a child has been in foster care for six months, a court review under section 260C.202 may be conducted in lieu of a permanency progress review hearing under section 260C.204 when the child is colocated with a parent consistent with section 260C.503, subdivision 3, paragraph (c), in a licensed residential family-based substance use disorder treatment program.

(c) If the child is colocated with a parent in a licensed residential family-based substance use disorder treatment program 12 months after the child was placed in foster care, the agency must file a report with the court regarding the parent's progress in the treatment program and the agency's reasonable efforts to finalize the child's safe and permanent return to the care and custody of the parent consistent with section 260C.503, subdivision 3, paragraph (c), in lieu of filing a petition required under section 260C.505.

(d) The court shall make findings regarding the reasonable efforts of the agency to finalize the child's return home as the permanency disposition order in the child's best interests. The court may continue the child's foster care placement colocated with a parent in a licensed residential family-based substance use disorder treatment program for up to 12 months. When a child has been in foster care placement for 12 months, but the duration of the colocation with a parent in a licensed residential family-based substance use disorder treatment program is less than 12 months, the court may continue the colocation with the total time spent in foster care not exceeding 15 out of the most recent 22 months. If the court finds that the agency fails to make reasonable efforts to finalize the child's return home as the permanency disposition order in the child's best interests, the court may order additional efforts to support the child remaining in the care of the parent.

(e) If a parent leaves or is discharged from a licensed residential family-based substance use disorder treatment program without completing the program, the child's placement under this section is terminated and the agency may remove the child to foster care without a prior court order or authorization. Within three days of any termination of a child's placement, the agency shall notify the court and each party.

(f) If a parent leaves or is discharged from a licensed residential family-based substance use disorder treatment program without completing the program and the child has been in foster care for less than six months, the court must hold a review hearing within ten days of receiving notice of a termination of a child's placement and must order an alternative disposition under section 260C.201.

(g) If a parent leaves or is discharged from a licensed residential family-based substance use disorder treatment program without completing the program and the child is colocated with a parent and the child has been in foster care for more than six months but less than 12 months, the court must conduct a permanency progress review hearing under section 260C.204 no later than 30 days after the day the parent leaves or is discharged.

(h) If a parent leaves or is discharged from a licensed residential family-based substance use disorder treatment program without completing the program and the child is colocated

with a parent and the child has been in foster care for more than 12 months, the court shall begin permanency proceedings under sections 260C.503 to 260C.521.

Sec. 35. Minnesota Statutes 2018, section 260C.201, subdivision 1, is amended to read:

Subdivision 1. **Dispositions.** (a) If the court finds that the child is in need of protection or services or neglected and in foster care, it shall enter an order making any of the following dispositions of the case:

(1) place the child under the protective supervision of the responsible social services agency or child-placing agency in the home of a parent of the child under conditions prescribed by the court directed to the correction of the child's need for protection or services:

(i) the court may order the child into the home of a parent who does not otherwise have legal custody of the child, however, an order under this section does not confer legal custody on that parent;

(ii) if the court orders the child into the home of a father who is not adjudicated, the father must cooperate with paternity establishment proceedings regarding the child in the appropriate jurisdiction as one of the conditions prescribed by the court for the child to continue in the father's home; and

(iii) the court may order the child into the home of a noncustodial parent with conditions and may also order both the noncustodial and the custodial parent to comply with the requirements of a case plan under subdivision 2; or

(2) transfer legal custody to one of the following:

(i) a child-placing agency; or

(ii) the responsible social services agency. In making a foster care placement for a child whose custody has been transferred under this subdivision, the agency shall make an individualized determination of how the placement is in the child's best interests using the consideration for relatives ~~and~~, the best interest factors in section 260C.212, subdivision 2, paragraph (b), and may include a child colocated with a parent in a licensed residential family-based substance use disorder treatment program under section 260C.190; or

(3) order a trial home visit without modifying the transfer of legal custody to the responsible social services agency under clause (2). Trial home visit means the child is returned to the care of the parent or guardian from whom the child was removed for a period not to exceed six months. During the period of the trial home visit, the responsible social services agency:

(i) shall continue to have legal custody of the child, which means the agency may see the child in the parent's home, at school, in a child care facility, or other setting as the agency deems necessary and appropriate;

(ii) shall continue to have the ability to access information under section 260C.208;

(iii) shall continue to provide appropriate services to both the parent and the child during the period of the trial home visit;

(iv) without previous court order or authorization, may terminate the trial home visit in order to protect the child's health, safety, or welfare and may remove the child to foster care;

(v) shall advise the court and parties within three days of the termination of the trial home visit when a visit is terminated by the responsible social services agency without a court order; and

(vi) shall prepare a report for the court when the trial home visit is terminated whether by the agency or court order which describes the child's circumstances during the trial home visit and recommends appropriate orders, if any, for the court to enter to provide for the child's safety and stability. In the event a trial home visit is terminated by the agency by removing the child to foster care without prior court order or authorization, the court shall conduct a hearing within ten days of receiving notice of the termination of the trial home visit by the agency and shall order disposition under this subdivision or ~~conduct a permanency hearing under subdivision 11 or 11a~~ commence permanency proceedings under sections 260C.503 to 260C.515. The time period for the hearing may be extended by the court for good cause shown and if it is in the best interests of the child as long as the total time the child spends in foster care without a permanency hearing does not exceed 12 months;

(4) if the child has been adjudicated as a child in need of protection or services because the child is in need of special services or care to treat or ameliorate a physical or mental disability or emotional disturbance as defined in section 245.4871, subdivision 15, the court may order the child's parent, guardian, or custodian to provide it. The court may order the child's health plan company to provide mental health services to the child. Section 62Q.535 applies to an order for mental health services directed to the child's health plan company. If the health plan, parent, guardian, or custodian fails or is unable to provide this treatment or care, the court may order it provided. Absent specific written findings by the court that the child's disability is the result of abuse or neglect by the child's parent or guardian, the court shall not transfer legal custody of the child for the purpose of obtaining special treatment or care solely because the parent is unable to provide the treatment or care. If the court's order for mental health treatment is based on a diagnosis made by a treatment

professional, the court may order that the diagnosing professional not provide the treatment to the child if it finds that such an order is in the child's best interests; or

(5) if the court believes that the child has sufficient maturity and judgment and that it is in the best interests of the child, the court may order a child 16 years old or older to be allowed to live independently, either alone or with others as approved by the court under supervision the court considers appropriate, if the county board, after consultation with the court, has specifically authorized this dispositional alternative for a child.

(b) If the child was adjudicated in need of protection or services because the child is a runaway or habitual truant, the court may order any of the following dispositions in addition to or as alternatives to the dispositions authorized under paragraph (a):

(1) counsel the child or the child's parents, guardian, or custodian;

(2) place the child under the supervision of a probation officer or other suitable person in the child's own home under conditions prescribed by the court, including reasonable rules for the child's conduct and the conduct of the parents, guardian, or custodian, designed for the physical, mental, and moral well-being and behavior of the child;

(3) subject to the court's supervision, transfer legal custody of the child to one of the following:

(i) a reputable person of good moral character. No person may receive custody of two or more unrelated children unless licensed to operate a residential program under sections 245A.01 to 245A.16; or

(ii) a county probation officer for placement in a group foster home established under the direction of the juvenile court and licensed pursuant to section 241.021;

(4) require the child to pay a fine of up to $100. The court shall order payment of the fine in a manner that will not impose undue financial hardship upon the child;

(5) require the child to participate in a community service project;

(6) order the child to undergo a chemical dependency evaluation and, if warranted by the evaluation, order participation by the child in a drug awareness program or an inpatient or outpatient chemical dependency treatment program;

(7) if the court believes that it is in the best interests of the child or of public safety that the child's driver's license or instruction permit be canceled, the court may order the commissioner of public safety to cancel the child's license or permit for any period up to the child's 18th birthday. If the child does not have a driver's license or permit, the court

may order a denial of driving privileges for any period up to the child's 18th birthday. The court shall forward an order issued under this clause to the commissioner, who shall cancel the license or permit or deny driving privileges without a hearing for the period specified by the court. At any time before the expiration of the period of cancellation or denial, the court may, for good cause, order the commissioner of public safety to allow the child to apply for a license or permit, and the commissioner shall so authorize;

(8) order that the child's parent or legal guardian deliver the child to school at the beginning of each school day for a period of time specified by the court; or

(9) require the child to perform any other activities or participate in any other treatment programs deemed appropriate by the court.

To the extent practicable, the court shall enter a disposition order the same day it makes a finding that a child is in need of protection or services or neglected and in foster care, but in no event more than 15 days after the finding unless the court finds that the best interests of the child will be served by granting a delay. If the child was under eight years of age at the time the petition was filed, the disposition order must be entered within ten days of the finding and the court may not grant a delay unless good cause is shown and the court finds the best interests of the child will be served by the delay.

(c) If a child who is 14 years of age or older is adjudicated in need of protection or services because the child is a habitual truant and truancy procedures involving the child were previously dealt with by a school attendance review board or county attorney mediation program under section 260A.06 or 260A.07, the court shall order a cancellation or denial of driving privileges under paragraph (b), clause (7), for any period up to the child's 18th birthday.

(d) In the case of a child adjudicated in need of protection or services because the child has committed domestic abuse and been ordered excluded from the child's parent's home, the court shall dismiss jurisdiction if the court, at any time, finds the parent is able or willing to provide an alternative safe living arrangement for the child, as defined in Laws 1997, chapter 239, article 10, section 2.

(e) When a parent has complied with a case plan ordered under subdivision 6 and the child is in the care of the parent, the court may order the responsible social services agency to monitor the parent's continued ability to maintain the child safely in the home under such terms and conditions as the court determines appropriate under the circumstances.

Sec. 36. Minnesota Statutes 2018, section 260C.201, subdivision 2, is amended to read:

Subd. 2. **Written findings.** (a) Any order for a disposition authorized under this section shall contain written findings of fact to support the disposition and case plan ordered and shall also set forth in writing the following information:

(1) why the best interests and safety of the child are served by the disposition and case plan ordered;

(2) what alternative dispositions or services under the case plan were considered by the court and why such dispositions or services were not appropriate in the instant case;

(3) when legal custody of the child is transferred, the appropriateness of the particular placement made or to be made by the placing agency using the factors in section 260C.212, subdivision 2, paragraph (b), or the appropriateness of a child colocated with a parent in a licensed residential family-based substance use disorder treatment program under section 260C.190;

(4) whether reasonable efforts to finalize the permanent plan for the child consistent with section 260.012 were made including reasonable efforts:

(i) to prevent the child's placement and to reunify the child with the parent or guardian from whom the child was removed at the earliest time consistent with the child's safety. The court's findings must include a brief description of what preventive and reunification efforts were made and why further efforts could not have prevented or eliminated the necessity of removal or that reasonable efforts were not required under section 260.012 or 260C.178, subdivision 1;

(ii) to identify and locate any noncustodial or nonresident parent of the child and to assess such parent's ability to provide day-to-day care of the child, and, where appropriate, provide services necessary to enable the noncustodial or nonresident parent to safely provide day-to-day care of the child as required under section 260C.219, unless such services are not required under section 260.012 or 260C.178, subdivision 1;

(iii) to make the diligent search for relatives and provide the notices required under section 260C.221; a finding made pursuant to a hearing under section 260C.202 that the agency has made diligent efforts to conduct a relative search and has appropriately engaged relatives who responded to the notice under section 260C.221 and other relatives, who came to the attention of the agency after notice under section 260C.221 was sent, in placement and case planning decisions fulfills the requirement of this item;

(iv) to identify and make a foster care placement in the home of an unlicensed relative, according to the requirements of section 245A.035, a licensed relative, or other licensed foster care provider who will commit to being the permanent legal parent or custodian for the child in the event reunification cannot occur, but who will actively support the reunification plan for the child; and

(v) to place siblings together in the same home or to ensure visitation is occurring when siblings are separated in foster care placement and visitation is in the siblings' best interests under section 260C.212, subdivision 2, paragraph (d); and

(5) if the child has been adjudicated as a child in need of protection or services because the child is in need of special services or care to treat or ameliorate a mental disability or emotional disturbance as defined in section 245.4871, subdivision 15, the written findings shall also set forth:

(i) whether the child has mental health needs that must be addressed by the case plan;

(ii) what consideration was given to the diagnostic and functional assessments performed by the child's mental health professional and to health and mental health care professionals' treatment recommendations;

(iii) what consideration was given to the requests or preferences of the child's parent or guardian with regard to the child's interventions, services, or treatment; and

(iv) what consideration was given to the cultural appropriateness of the child's treatment or services.

(b) If the court finds that the social services agency's preventive or reunification efforts have not been reasonable but that further preventive or reunification efforts could not permit the child to safely remain at home, the court may nevertheless authorize or continue the removal of the child.

(c) If the child has been identified by the responsible social services agency as the subject of concurrent permanency planning, the court shall review the reasonable efforts of the agency to develop a permanency plan for the child that includes a primary plan which is for reunification with the child's parent or guardian and a secondary plan which is for an alternative, legally permanent home for the child in the event reunification cannot be achieved in a timely manner.

Sec. 37. Minnesota Statutes 2018, section 260C.201, subdivision 6, is amended to read:

Subd. 6. **Case plan.** (a) For each disposition ordered where the child is placed away from a parent or guardian, the court shall order the responsible social services agency to prepare a written out-of-home placement plan according to the requirements of section 260C.212, subdivision 1. When a foster child is colocated with a parent in a licensed residential family-based substance use disorder treatment program under section 260C.190, the case plan must specify the recommendation for the colocation before the child is colocated with the parent.

(b) In cases where the child is not placed out of the home or is ordered into the home of a noncustodial parent, the responsible social services agency shall prepare a plan for delivery of social services to the child and custodial parent under section 626.556, subdivision 10, or any other case plan required to meet the needs of the child. The plan shall be designed to safely maintain the child in the home or to reunite the child with the custodial parent.

(c) The court may approve the case plan as presented or modify it after hearing from the parties. Once the plan is approved, the court shall order all parties to comply with it. A copy of the approved case plan shall be attached to the court's order and incorporated into it by reference.

(d) A party has a right to request a court review of the reasonableness of the case plan upon a showing of a substantial change of circumstances.

Sec. 38. Minnesota Statutes 2018, section 260C.212, subdivision 2, is amended to read:

Subd. 2. **Placement decisions based on best interests of the child.** (a) The policy of the state of Minnesota is to ensure that the child's best interests are met by requiring an individualized determination of the needs of the child and of how the selected placement will serve the needs of the child being placed. The authorized child-placing agency shall place a child, released by court order or by voluntary release by the parent or parents, in a family foster home selected by considering placement with relatives and important friends in the following order:

(1) with an individual who is related to the child by blood, marriage, or adoption; or

(2) with an individual who is an important friend with whom the child has resided or had significant contact.

For an Indian child, the agency shall follow the order of placement preferences in the Indian Child Welfare Act of 1978, United States Code, title 25, section 1915.

(b) Among the factors the agency shall consider in determining the needs of the child are the following:

(1) the child's current functioning and behaviors;

(2) the medical needs of the child;

(3) the educational needs of the child;

(4) the developmental needs of the child;

(5) the child's history and past experience;

(6) the child's religious and cultural needs;

(7) the child's connection with a community, school, and faith community;

(8) the child's interests and talents;

(9) the child's relationship to current caretakers, parents, siblings, and relatives;

(10) the reasonable preference of the child, if the court, or the child-placing agency in the case of a voluntary placement, deems the child to be of sufficient age to express preferences; and

(11) for an Indian child, the best interests of an Indian child as defined in section 260.755, subdivision 2a.

(c) Placement of a child cannot be delayed or denied based on race, color, or national origin of the foster parent or the child.

(d) Siblings should be placed together for foster care and adoption at the earliest possible time unless it is documented that a joint placement would be contrary to the safety or well-being of any of the siblings or unless it is not possible after reasonable efforts by the responsible social services agency. In cases where siblings cannot be placed together, the agency is required to provide frequent visitation or other ongoing interaction between siblings unless the agency documents that the interaction would be contrary to the safety or well-being of any of the siblings.

(e) Except for emergency placement as provided for in section 245A.035, the following requirements must be satisfied before the approval of a foster or adoptive placement in a related or unrelated home: (1) a completed background study under section 245C.08; and (2) a completed review of the written home study required under section 260C.215, subdivision 4, clause (5), or 260C.611, to assess the capacity of the prospective foster or adoptive parent to ensure the placement will meet the needs of the individual child.

(f) The agency must determine whether colocation with a parent who is receiving services in a licensed residential family-based substance use disorder treatment program is in the child's best interests according to paragraph (b) and include that determination in the child's case plan. The agency may consider additional factors not identified in paragraph (b). The agency's determination must be documented in the child's case plan before the child is colocated with a parent.

Sec. 39. **[260C.228] VOLUNTARY FOSTER CARE; CHILD IS COLOCATED WITH PARENT IN TREATMENT PROGRAM.**

Subdivision 1. **Generally.** When a parent requests assistance from an agency and both the parent and agency agree that a child's placement in foster care and colocation with a parent in a licensed residential family-based substance use treatment facility as defined by section 260C.007, subdivision 22a, is in the child's best interests, the agency must specify the recommendation for the placement in the child's case plan. After the child's case plan includes the recommendation, the agency and the parent may enter into a written voluntary placement agreement on a form approved by the commissioner.

Subd. 2. **Judicial review.** (a) A judicial review of a child's voluntary placement is required within 165 days of the date the voluntary agreement was signed. The agency responsible for the child's placement in foster care shall request the judicial review.

(b) The agency must forward a written report to the court at least five business days prior to the judicial review in paragraph (a). The report must contain:

(i) a statement regarding whether the colocation of the child with a parent in a licensed residential family-based substance use disorder treatment program meets the child's needs and continues to be in the child's best interests;

(ii) the child's name, dates of birth, race, gender, and current address;

(iii) the names, race, dates of birth, residences, and post office addresses of the child's parents or custodian;

(iv) a statement regarding the child's eligibility for membership or enrollment in an Indian tribe and the agency's compliance with applicable provisions of sections 260.751 to 260.835;

(v) the name and address of the licensed residential family-based substance use disorder treatment program where the child and parent or custodian are colocated;

(vi) a copy of the out-of-home placement plan under section 260C.212, subdivisions 1 and 3;

(vii) a written summary of the proceedings of any administrative review required under section 260C.203; and

(viii) any other information the agency, parent or custodian, child, or licensed residential family-based substance use disorder treatment program wants the court to consider.

(c) The agency must inform a child, if the child is 12 years of age or older; the child's parent; and the licensed residential family-based substance use disorder treatment program of the reporting and court review requirements of this section and of their rights to submit information to the court as follows:

(1) if the child, the child's parent, or the licensed residential family-based substance use disorder treatment program wants to send information to the court, the agency shall advise those persons of the reporting date and the date by which the agency must receive the information to submit to the court with the agency's report; and

(2) the agency must inform the child, the child's parent, and the licensed residential family-based substance use disorder treatment program that they have the right to be heard in person by the court. An in-person hearing must be held if requested by the child, parent or legal guardian, or licensed residential family-based substance use disorder treatment program.

(d) If, at the time required for the agency's report under this section, a child 12 years of age or older disagrees about the placement colocating the child with the parent in a licensed residential family-based substance use disorder treatment program or services provided under the out-of-home placement plan under section 260C.212, subdivision 1, the agency shall include information regarding the child's disagreement and to the extent possible the basis for the child's disagreement in the report.

(e) Regardless of whether an in-person hearing is requested within ten days of receiving the agency's report, the court has jurisdiction to and must determine:

(i) whether the voluntary foster care arrangement is in the child's best interests;

(ii) whether the parent and agency are appropriately planning for the child; and

(iii) if a child 12 years of age or older disagrees with the foster care placement colocating the child with the parent in a licensed residential family-based substance use disorder treatment program or services provided under the out-of-home placement plan, whether to appoint counsel and a guardian ad litem for the child according to section 260C.163.

(f) Unless requested by the parent, representative of the licensed residential family-based substance use disorder treatment program, or child, an in-person hearing is not required for the court to make findings and issue an order.

(g) If the court finds the voluntary foster care arrangement is in the child's best interests and that the agency and parent are appropriately planning for the child, the court shall issue an order containing explicit individualized findings to support the court's determination. The individual findings shall be based on the agency's written report and other materials submitted to the court. The court may make this determination notwithstanding the child's disagreement, if any, reported to the court under paragraph (d).

(h) The court shall send a copy of the order to the county attorney, the agency, the parent, a child 12 years of age or older, and the licensed residential family-based substance use disorder treatment program.

(i) If the court finds continuing the voluntary foster care arrangement is not in the child's best interests or that the agency or the parent is not appropriately planning for the child, the court shall notify the agency, the parent, the licensed residential family-based substance use disorder treatment program, a child 12 years of age or older, and the county attorney of the court's determination and the basis for the court's determination. The court shall set the matter for hearing and appoint a guardian ad litem for the child under section 260C.163, subdivision 5.

Subd. 3. **Termination.** The voluntary placement agreement terminates at the parent's discharge from the licensed residential family-based substance use disorder treatment program, or upon receipt of a written and dated request from the parent, unless the request specifies a later date. If the child's voluntary foster care placement meets the calculated time to require a permanency proceeding under section 260C.503, subdivision 3, paragraph (a), and the child is not returned home, the agency must file a petition according to section 260C.141 or 260C.505.

Sec. 40. Minnesota Statutes 2018, section 260C.452, subdivision 4, is amended to read:

Subd. 4. **Administrative or court review of placements.** (a) When the child is 14 years of age or older, the court, in consultation with the child, shall review the independent living plan according to section 260C.203, paragraph (d).

(b) The responsible social services agency shall file a copy of the notification required in subdivision 3 with the court. If the responsible social services agency does not file the

notice by the time the child is 17-1/2 years of age, the court shall require the responsible social services agency to file the notice.

(c) The court shall ensure that the responsible social services agency assists the child in obtaining the following documents before the child leaves foster care: a Social Security card; an official or certified copy of the child's birth certificate; a state identification card or driver's license, tribal enrollment identification card, green card, or school visa; health insurance information; the child's school, medical, and dental records; a contact list of the child's medical, dental, and mental health providers; and contact information for the child's siblings, if the siblings are in foster care.

(d) For a child who will be discharged from foster care at 18 years of age or older, the responsible social services agency must develop a personalized transition plan as directed by the child during the 90-day period immediately prior to the expected date of discharge. The transition plan must be as detailed as the child elects and include specific options, including but not limited to:

(1) affordable housing with necessary supports that does not include a homeless shelter;

(2) health insurance, including eligibility for medical assistance as defined in section 256B.055, subdivision 17;

(3) education, including application to the Education and Training Voucher Program;

(4) local opportunities for mentors and continuing support services, including the Healthy Transitions and Homeless Prevention program, if available;

(5) workforce supports and employment services;

(6) a copy of the child's consumer credit report as defined in section 13C.001 and assistance in interpreting and resolving any inaccuracies in the report, at no cost to the child;

(7) information on executing a health care directive under chapter 145C and on the importance of designating another individual to make health care decisions on behalf of the child if the child becomes unable to participate in decisions; ~~and~~

(8) appropriate contact information through 21 years of age if the child needs information or help dealing with a crisis situation~~.~~; and

(9) official documentation that the youth was previously in foster care.

Sec. 41. Minnesota Statutes 2018, section 260C.503, subdivision 1, is amended to read:

Subdivision 1. **Required permanency proceedings.** (a) Except for children in foster care pursuant to chapter 260D, where the child is in foster care or in the care of a noncustodial or nonresident parent, the court shall commence proceedings to determine the permanent status of a child by holding the admit-deny hearing required under section 260C.507 not later than 12 months after the child is placed in foster care or in the care of a noncustodial or nonresident parent. Permanency proceedings for children in foster care pursuant to chapter 260D shall be according to section 260D.07.

(b) Permanency proceedings for a foster child who is colocated with a parent in a licensed residential family-based substance use disorder treatment program shall be conducted according to section 260C.190.

Sec. 42. Minnesota Statutes 2018, section 518A.32, subdivision 3, is amended to read:

Subd. 3. **Parent not considered voluntarily unemployed, underemployed, or employed on a less than full-time basis.** A parent is not considered voluntarily unemployed, underemployed, or employed on a less than full-time basis upon a showing by the parent that:

(1) the unemployment, underemployment, or employment on a less than full-time basis is temporary and will ultimately lead to an increase in income;

(2) the unemployment, underemployment, or employment on a less than full-time basis represents a bona fide career change that outweighs the adverse effect of that parent's diminished income on the child; or

(3) the unemployment, underemployment, or employment on a less than full-time basis is because a parent is physically or mentally incapacitated or due to incarceration~~, except where the reason for incarceration is the parent's nonpayment of support~~.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 43. **INSTRUCTION TO COMMISSIONER.**

All individuals in connection with a licensed children's residential facility required to complete a background study under Minnesota Statutes, chapter 245C, must complete a new background study consistent with the obligations and requirements of this article. The commissioner of human services shall establish a schedule for (1) individuals in connection with a licensed children's residential facility that serves children eligible to receive federal Title IV-E funding to complete the new background study by March 1, 2020, and (2)

individuals in connection with a licensed children's residential facility that serves children not eligible to receive federal Title IV-E funding to complete the new background study by March 1, 2021.

Sec. 44. **CHILD WELFARE TRAINING ACADEMY.**

Subdivision 1. **Establishment; purpose.** The commissioner of human services shall modify the Child Welfare Training System developed pursuant to Minnesota Statutes, section 626.5591, subdivision 2, according to this section. The new training framework shall be known as the Child Welfare Training Academy.

Subd. 2. **Administration.** (a) The Child Welfare Training Academy must be administered through five regional hubs in northwest, northeast, southwest, southeast, and central Minnesota. Each hub must deliver training targeted to the needs of the hub's particular region, taking into account varying demographics, resources, and practice outcomes.

(b) The Child Welfare Training Academy must use training methods best suited to the training content. National best practices in adult learning must be used to the greatest extent possible, including online learning methodologies, coaching, mentoring, and simulated skill application.

(c) Each child welfare worker and supervisor must complete a certification, including a competency-based knowledge test and a skills demonstration, at the completion of the worker's or supervisor's initial training and biennially thereafter. The commissioner shall develop ongoing training requirements and a method for tracking certifications.

(d) Each regional hub must have a regional organizational effectiveness specialist trained in continuous quality improvement strategies. The specialist shall provide organizational change assistance to counties and tribes, with priority given to efforts intended to impact child safety.

(e) The Child Welfare Training Academy must include training and resources that address worker well-being and secondary traumatic stress.

(f) The Child Welfare Training Academy must serve the primary training audiences of (1) county and tribal child welfare workers, (2) county and tribal child welfare supervisors, and (3) staff at private agencies providing out-of-home placement services for children involved in Minnesota's county and tribal child welfare system.

Subd. 3. **Partnerships.** (a) The commissioner of human services shall enter into a partnership with the University of Minnesota to collaborate in the administration of workforce training.

(b) The commissioner of human services shall enter into a partnership with one or more agencies to provide consultation, subject matter expertise, and capacity building in organizational resilience and child welfare workforce well-being.

Subd. 4. **Rulemaking.** The commissioner of human services may adopt rules by December 31, 2020, as necessary to establish the Child Welfare Training Academy. If the commissioner of human services does not adopt rules by July 1, 2023, rulemaking authority under this section is repealed. Rulemaking authority under this section is not continuing authority to amend or repeal rules. Any additional action on rules after adoption must be under specific statutory authority to take the additional action.

Sec. 45. **CHILD WELFARE CASELOAD STUDY.**

(a) The commissioner of human services shall conduct a child welfare caseload study to collect data on (1) the number of child welfare workers in Minnesota, and (2) the amount of time that child welfare workers spend on different components of child welfare work. The study must be completed by July 1, 2020.

(b) The commissioner shall report the results of the child welfare caseload study to the governor and to the chairs and ranking minority members of the committees in the house of representatives and senate with jurisdiction over human services by December 1, 2020.

(c) After the child welfare caseload study is complete, the commissioner shall work with counties and other stakeholders to develop a process for ongoing monitoring of child welfare workers' caseloads.

Sec. 46. **REPEALER.**

(a) Minnesota Statutes 2018, sections 119B.16, subdivision 2; and 245E.06, subdivisions 2, 4, and 5, are repealed effective the day following final enactment.

(b) Minnesota Rules, part 3400.0185, subpart 5, is repealed effective February 26, 2021.

(c) Minnesota Rules, part 2960.3030, subpart 3, is repealed.

ARTICLE 2
OPERATIONS

Section 1. Minnesota Statutes 2018, section 15C.02, is amended to read:

15C.02 LIABILITY FOR CERTAIN ACTS.

(a) A person who commits any act described in clauses (1) to (7) is liable to the state or the political subdivision for a civil penalty ~~of not less than $5,500 and not more than $11,000 per false or fraudulent claim~~ in the amounts set forth in the federal False Claims Act, United States Code, title 31, section 3729, and as modified by the federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015, plus three times the amount of damages that the state or the political subdivision sustains because of the act of that person, except as otherwise provided in paragraph (b):

(1) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;

(2) knowingly makes or uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;

(3) knowingly conspires to commit a violation of clause (1), (2), (4), (5), (6), or (7);

(4) has possession, custody, or control of property or money used, or to be used, by the state or a political subdivision and knowingly delivers or causes to be delivered less than all of that money or property;

(5) is authorized to make or deliver a document certifying receipt for money or property used, or to be used, by the state or a political subdivision and, intending to defraud the state or a political subdivision, makes or delivers the receipt without completely knowing that the information on the receipt is true;

(6) knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the state or a political subdivision who lawfully may not sell or pledge the property; or

(7) knowingly makes or uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the state or a political subdivision, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the state or a political subdivision.

(b) Notwithstanding paragraph (a), the court may assess not less than two times the amount of damages that the state or the political subdivision sustains because of the act of the person if:

(1) the person committing a violation under paragraph (a) furnished an officer or employee of the state or the political subdivision responsible for investigating the false or fraudulent claim violation with all information known to the person about the violation within 30 days after the date on which the person first obtained the information;

(2) the person fully cooperated with any investigation by the state or the political subdivision of the violation; and

(3) at the time the person furnished the state or the political subdivision with information about the violation, no criminal prosecution, civil action, or administrative action had been commenced under this chapter with respect to the violation and the person did not have actual knowledge of the existence of an investigation into the violation.

(c) A person violating this section is also liable to the state or the political subdivision for the costs of a civil action brought to recover any penalty or damages.

(d) A person is not liable under this section for mere negligence, inadvertence, or mistake with respect to activities involving a false or fraudulent claim.

Sec. 2. Minnesota Statutes 2018, section 245A.02, subdivision 18, is amended to read:

Subd. 18. **Supervision.** (a) For purposes of licensed child care centers, "supervision" means when a program staff person:

(1) is ~~within sight and hearing of a child at all times so that the program staff~~ accountable for the child's care;

(2) can intervene to protect the health and safety of the child~~.~~; and

(3) is within sight and hearing of the child at all times except as described in paragraphs (b) to (d).

(b) When an infant is placed in a crib room to sleep, supervision occurs when a program staff person is within sight or hearing of the infant. When supervision of a crib room is provided by sight or hearing, the center must have a plan to address the other supervision ~~component~~ components.

(c) When a single school-age child uses the restroom within the licensed space, supervision occurs when a program staff person has knowledge of the child's activity and location and checks on the child at least every five minutes. When a school-age child uses

the restroom outside the licensed space, including but not limited to field trips, supervision occurs when staff accompany children to the restroom.

(d) When a school-age child leaves the classroom but remains within the licensed space to deliver or retrieve items from the child's personal storage space, supervision occurs when a program staff person has knowledge of the child's activity and location and checks on the child at least every five minutes.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 3. Minnesota Statutes 2018, section 245A.14, subdivision 4, is amended to read:

Subd. 4. **Special family day care homes.** Nonresidential child care programs serving 14 or fewer children that are conducted at a location other than the license holder's own residence shall be licensed under this section and the rules governing family day care or group family day care if:

(a) the license holder is the primary provider of care and the nonresidential child care program is conducted in a dwelling that is located on a residential lot;

(b) the license holder is an employer who may or may not be the primary provider of care, and the purpose for the child care program is to provide child care services to children of the license holder's employees;

(c) the license holder is a church or religious organization;

(d) the license holder is a community collaborative child care provider. For purposes of this subdivision, a community collaborative child care provider is a provider participating in a cooperative agreement with a community action agency as defined in section 256E.31;

(e) the license holder is a not-for-profit agency that provides child care in a dwelling located on a residential lot and the license holder maintains two or more contracts with community employers or other community organizations to provide child care services. The county licensing agency may grant a capacity variance to a license holder licensed under this paragraph to exceed the licensed capacity of 14 children by no more than five children during transition periods related to the work schedules of parents, if the license holder meets the following requirements:

(1) the program does not exceed a capacity of 14 children more than a cumulative total of four hours per day;

(2) the program meets a one to seven staff-to-child ratio during the variance period;

(3) all employees receive at least an extra four hours of training per year than required in the rules governing family child care each year;

(4) the facility has square footage required per child under Minnesota Rules, part 9502.0425;

(5) the program is in compliance with local zoning regulations;

(6) the program is in compliance with the applicable fire code as follows:

(i) if the program serves more than five children older than 2-1/2 years of age, but no more than five children 2-1/2 years of age or less, the applicable fire code is educational occupancy, as provided in Group E Occupancy under the Minnesota State Fire Code ~~2003~~ 2015, Section 202; or

(ii) if the program serves more than five children 2-1/2 years of age or less, the applicable fire code is Group I-4 Occupancies, as provided in the Minnesota State Fire Code ~~2003~~ 2015, Section 202, unless the rooms in which the children are cared for are located on a level of exit discharge and each of these child care rooms has an exit door directly to the exterior, then the applicable fire code is Group E occupancies, as provided in the Minnesota State Fire Code 2015, Section 202; and

(7) any age and capacity limitations required by the fire code inspection and square footage determinations shall be printed on the license; or

(f) the license holder is the primary provider of care and has located the licensed child care program in a commercial space, if the license holder meets the following requirements:

(1) the program is in compliance with local zoning regulations;

(2) the program is in compliance with the applicable fire code as follows:

(i) if the program serves more than five children older than 2-1/2 years of age, but no more than five children 2-1/2 years of age or less, the applicable fire code is educational occupancy, as provided in Group E Occupancy under the Minnesota State Fire Code ~~2003~~ 2015, Section 202; or

(ii) if the program serves more than five children 2-1/2 years of age or less, the applicable fire code is Group I-4 Occupancies, as provided under the Minnesota State Fire Code ~~2003~~ 2015, Section 202;

(3) any age and capacity limitations required by the fire code inspection and square footage determinations are printed on the license; and

(4) the license holder prominently displays the license issued by the commissioner which contains the statement "This special family child care provider is not licensed as a child care center."

(g) The commissioner may approve two or more licenses under paragraphs (a) to (f) to be issued at the same location or under one contiguous roof, if each license holder is able to demonstrate compliance with all applicable rules and laws. Each license holder must operate the license holder's own respective licensed program as a distinct program and within the capacity, age, and ratio distributions of each license.

(h) The commissioner may grant variances to this section to allow a primary provider of care, a not-for-profit organization, a church or religious organization, an employer, or a community collaborative to be licensed to provide child care under paragraphs (e) and (f) if the license holder meets the other requirements of the statute.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 4. Minnesota Statutes 2018, section 245A.14, subdivision 8, is amended to read:

Subd. 8. **Experienced aides; child care centers.** (a) An individual employed as an aide at a child care center may work with children without being directly supervised for an amount of time that does not exceed 25 percent of the child care center's daily hours if:

(1) a teacher is in the facility;

~~(2) the individual has received within the last three years first aid training that meets the requirements under section 245A.40, subdivision 3, and CPR training that meets the requirements under section 245A.40, subdivision 4;~~

~~(3)~~ (2) the individual is at least 20 years old; and

~~(4)~~ (3) the individual has at least 4,160 hours of child care experience as a staff member in a licensed child care center or as the license holder of a family day care home, 120 days of which must be in the employment of the current company.

(b) A child care center that uses experienced aides under this subdivision must notify parents or guardians by posting the notification in each classroom that uses experienced aides, identifying which staff member is the experienced aide. Records of experienced aide usage must be kept on site and given to the commissioner upon request.

(c) A child care center may not use the experienced aide provision for one year following two determined experienced aide violations within a one-year period.

(d) A child care center may use one experienced aide per every four full-time child care classroom staff.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 5. Minnesota Statutes 2018, section 245A.14, is amended by adding a subdivision to read:

Subd. 16. **Valid driver's license.** Notwithstanding any law to the contrary, when a licensed child care center provides transportation for children or contracts to provide transportation for children, a person who has a current, valid driver's license appropriate to the vehicle driven may transport the child.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 6. Minnesota Statutes 2018, section 245A.14, is amended by adding a subdivision to read:

Subd. 17. **Reusable water bottles or cups.** Notwithstanding any law to the contrary, a child care center that meets the standards in Minnesota Rules, chapter 9503, may provide drinking water to a child in a reusable water bottle or reusable cup if the center develops and ensures implementation of a written policy that at a minimum includes the following procedures:

(1) each day the water bottle or cup is used, the child care center cleans and sanitizes the water bottle or cup using procedures that comply with the Food Code under Minnesota Rules, chapter 4626;

(2) water bottle or cup is assigned to a specific child and labeled with the child's first and last name;

(3) water bottles and cups are stored in a manner that reduces the risk of a child using the wrong water bottle or cup; and

(4) a water bottle or cup is used only for water.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 7. Minnesota Statutes 2018, section 245A.151, is amended to read:

245A.151 FIRE MARSHAL INSPECTION.

When licensure under this chapter or certification under chapter 245H requires an inspection by a fire marshal to determine compliance with the State Fire Code under section

299F.011, a local fire code inspector approved by the state fire marshal may conduct the inspection. If a community does not have a local fire code inspector or if the local fire code inspector does not perform the inspection, the state fire marshal must conduct the inspection. A local fire code inspector or the state fire marshal may recover the cost of these inspections through a fee of no more than $50 per inspection charged to the applicant or license holder or license-exempt child care center certification holder. The fees collected by the state fire marshal under this section are appropriated to the commissioner of public safety for the purpose of conducting the inspections.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 8. Minnesota Statutes 2018, section 245A.16, subdivision 1, is amended to read:

Subdivision 1. **Delegation of authority to agencies.** (a) County agencies and private agencies that have been designated or licensed by the commissioner to perform licensing functions and activities under section 245A.04 and background studies for family child care under chapter 245C; to recommend denial of applicants under section 245A.05; to issue correction orders, to issue variances, and recommend a conditional license under section 245A.06; or to recommend suspending or revoking a license or issuing a fine under section 245A.07, shall comply with rules and directives of the commissioner governing those functions and with this section. The following variances are excluded from the delegation of variance authority and may be issued only by the commissioner:

(1) dual licensure of family child care and child foster care, dual licensure of child and adult foster care, and adult foster care and family child care;

(2) adult foster care maximum capacity;

(3) adult foster care minimum age requirement;

(4) child foster care maximum age requirement;

(5) variances regarding disqualified individuals except that, before the implementation of NETStudy 2.0, county agencies may issue variances under section 245C.30 regarding disqualified individuals when the county is responsible for conducting a consolidated reconsideration according to sections 245C.25 and 245C.27, subdivision 2, clauses (a) and (b), of a county maltreatment determination and a disqualification based on serious or recurring maltreatment;

(6) the required presence of a caregiver in the adult foster care residence during normal sleeping hours; ~~and~~

(7) variances to requirements relating to chemical use problems of a license holder or a household member of a license holder.; and

(8) variances to section 245A.53 for a time-limited period. If the commissioner grants a variance under this clause, the license holder must provide notice of the variance to all parents and guardians of the children in care.

Except as provided in section 245A.14, subdivision 4, paragraph (e), a county agency must not grant a license holder a variance to exceed the maximum allowable family child care license capacity of 14 children.

(b) Before the implementation of NETStudy 2.0, county agencies must report information about disqualification reconsiderations under sections 245C.25 and 245C.27, subdivision 2, paragraphs (a) and (b), and variances granted under paragraph (a), clause (5), to the commissioner at least monthly in a format prescribed by the commissioner.

(c) For family child care programs, the commissioner shall require a county agency to conduct one unannounced licensing review at least annually.

(d) For family adult day services programs, the commissioner may authorize licensing reviews every two years after a licensee has had at least one annual review.

(e) A license issued under this section may be issued for up to two years.

(f) During implementation of chapter 245D, the commissioner shall consider:

(1) the role of counties in quality assurance;

(2) the duties of county licensing staff; and

(3) the possible use of joint powers agreements, according to section 471.59, with counties through which some licensing duties under chapter 245D may be delegated by the commissioner to the counties.

Any consideration related to this paragraph must meet all of the requirements of the corrective action plan ordered by the federal Centers for Medicare and Medicaid Services.

(g) Licensing authority specific to section 245D.06, subdivisions 5, 6, 7, and 8, or successor provisions; and section 245D.061 or successor provisions, for family child foster care programs providing out-of-home respite, as identified in section 245D.03, subdivision 1, paragraph (b), clause (1), is excluded from the delegation of authority to county and private agencies.

(h) A county agency shall report to the commissioner, in a manner prescribed by the commissioner, the following information for a licensed family child care program:

(1) the results of each licensing review completed, including the date of the review, and any licensing correction order issued; ~~and~~

(2) any death, serious injury, or determination of substantiated maltreatment~~.~~; and

(3) any fires that require the service of a fire department within 48 hours of the fire. The information under this clause must also be reported to the State Fire Marshal within 48 hours of the fire.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 9. Minnesota Statutes 2018, section 245A.40, is amended to read:

245A.40 CHILD CARE CENTER TRAINING REQUIREMENTS.

Subdivision 1. **Orientation.** (a) The child care center license holder must ensure that ~~every~~ the director, staff ~~person and volunteer is~~ persons, substitutes, and unsupervised volunteers are given orientation training and successfully ~~completes~~ complete the training before starting assigned duties. ~~The orientation training in this subdivision applies to volunteers who will have direct contact with or access to children and who are not under the direct supervision of a staff person. Completion of the orientation must be documented in the individual's personnel record.~~ The orientation training must include information about:

(1) the center's philosophy, child care program, and procedures for maintaining health and safety according to section 245A.41 and Minnesota Rules, part 9503.0140, and handling emergencies and accidents according to Minnesota Rules, part 9503.0110;

(2) specific job responsibilities;

(3) the behavior guidance standards in Minnesota Rules, part 9503.0055; ~~and~~

(4) the reporting responsibilities in section 626.556, and Minnesota Rules, part 9503.0130~~.~~;

(5) the center's drug and alcohol policy under section 245A.04, subdivision 1, paragraph (c);

(6) the center's risk reduction plan as required under section 245A.66, subdivision 2;

(7) at least one-half hour of training on the standards under section 245A.1435 and on reducing the risk of sudden unexpected infant death as required in subdivision 5, if applicable;

(8) at least one-half hour of training on the risk of abusive head trauma as required for the director and staff under subdivision 5a, if applicable; and

(9) training required by a child's individual child care program plan as required under Minnesota Rules, part 9503.0065, subpart 3, if applicable.

(b) In addition to paragraph (a), before having unsupervised direct contact with a child, the director and staff persons within the first 90 days of employment, and substitutes and unsupervised volunteers within 90 days after the first date of direct contact with a child, must complete:

(1) pediatric first aid, in accordance with subdivision 3; and

(2) pediatric cardiopulmonary resuscitation, in accordance with subdivision 4.

(c) In addition to paragraph (b), the director and staff persons within the first 90 days of employment, and substitutes and unsupervised volunteers within 90 days from the first date of direct contact with a child, must complete training in child development, in accordance with subdivision 2.

(d) The license holder must ensure that documentation, as required in subdivision 10, identifies the number of hours completed for each topic with a minimum training time identified, if applicable, and that all required content is included.

(e) Training in this subdivision must not be used to meet in-service training requirements in subdivision 7.

(f) Training completed within the previous 12 months under paragraphs (a), clauses (7) and (8), and (c) are transferable to another child care center.

Subd. 1a. **Definitions.** (a) For the purposes of this section, the following terms have the meanings given.

(b) "Substitute" means an adult who is temporarily filling a position as a director, teacher, assistant teacher, or aide in a licensed child care center for less than 240 hours total in a calendar year due to the absence of a regularly employed staff person.

(c) "Staff person" means an employee of a child care center who provides direct contact services to children.

(d) "Unsupervised volunteer" means an individual who:

(1) assists in the care of a child in care;

(2) is not under the continuous direct supervision of a staff person; and

(3) is not employed by the child care center.

Subd. 2. **Child development and learning training.** (a) ~~For purposes of child care centers,~~ The director and all staff ~~hired after July 1, 2006,~~ persons, substitutes, and unsupervised volunteers shall complete ~~and document at least two hours of~~ child development and learning training within the first 90 days of employment. The director and staff persons, not including substitutes, must complete at least two hours of training on child development and learning. The training for substitutes and unsupervised volunteers is not required to be of a minimum length. For purposes of this subdivision, "child development and learning training" means any training in Knowledge and Competency Area I: Child Development and Learning, which is training in understanding how children develop physically, cognitively, emotionally, and socially and learn as part of the children's family, culture, and community. ~~Training completed under this subdivision may be used to meet the in-service training requirements under subdivision 7.~~

(b) Notwithstanding paragraph (a), individuals are exempt from this requirement if they:

(1) have taken a three-credit college course on early childhood development within the past five years;

(2) have received a baccalaureate or master's degree in early childhood education or school-age child care within the past five years;

(3) are licensed in Minnesota as a prekindergarten teacher, an early childhood educator, a kindergarten to sixth grade teacher with a prekindergarten specialty, an early childhood special education teacher, or an elementary teacher with a kindergarten endorsement; or

(4) have received a baccalaureate degree with a Montessori certificate within the past five years.

(c) The director and staff persons, not including substitutes, must complete at least two hours of child development and learning training every second calendar year.

(d) Substitutes and unsupervised volunteers must complete child development and learning training every second calendar year. There is no minimum number of training hours required.

(e) Except for training required under paragraph (a), training completed under this subdivision may be used to meet the in-service training requirements under subdivision 7.

Subd. 3. **First aid.** (a) ~~All teachers and assistant teachers in a child care center governed by Minnesota Rules, parts 9503.0005 to 9503.0170, and at least one staff person during field trips and when transporting children in care, must satisfactorily complete pediatric first aid training within 90 days of the start of work, unless the training has been completed~~

~~within the previous two years.~~ Unless training has been completed within the previous two years, the director, staff persons, substitutes, and unsupervised volunteers must satisfactorily complete pediatric first aid training prior to having unsupervised direct contact with a child, but not to exceed the first 90 days of employment.

(b) ~~Notwithstanding paragraph (a), which allows 90 days to complete training, at least one staff person who has satisfactorily completed pediatric first aid training must be present at all times in the center, during field trips, and when transporting children in care.~~ Pediatric first aid training must be repeated at least every second calendar year. First aid training under this subdivision must be provided by an individual approved as a first aid instructor and must not be used to meet in-service training requirements under subdivision 7.

~~(c) The pediatric first aid training must be repeated at least every two years, documented in the person's personnel record and indicated on the center's staffing chart, and provided by an individual approved as a first aid instructor. This training may be less than eight hours.~~

Subd. 4. **Cardiopulmonary resuscitation.** ~~(a) All teachers and assistant teachers in a child care center governed by Minnesota Rules, parts 9503.0005 to 9503.0170, and at least one staff person during field trips and when transporting children in care, must satisfactorily complete training in cardiopulmonary resuscitation (CPR) that includes CPR techniques for infants and children and in the treatment of obstructed airways. The CPR training must be completed within 90 days of the start of work, unless the training has been completed within the previous two years. The CPR training must have been provided by an individual approved to provide CPR instruction, must be repeated at least once every two years, and must be documented in the staff person's records.~~

~~(b) Notwithstanding paragraph (a), which allows 90 days to complete training, at least one staff person who has satisfactorily completed cardiopulmonary resuscitation training must be present at all times in the center, during field trips, and when transporting children in care.~~

~~(c) CPR training may be provided for less than four hours.~~

~~(d) Persons providing CPR training must use CPR training that has been developed:~~

~~(1) by the American Heart Association or the American Red Cross and incorporates psychomotor skills to support the instruction; or~~

~~(2) using nationally recognized, evidence-based guidelines for CPR and incorporates psychomotor skills to support the instruction.~~

(a) Unless training has been completed within the previous two years, the director, staff persons, substitutes, and unsupervised volunteers must satisfactorily complete pediatric cardiopulmonary resuscitation (CPR) training that meets the requirements of this subdivision. Pediatric CPR training must be completed prior to having unsupervised direct contact with a child, but not to exceed the first 90 days of employment.

(b) Pediatric CPR training must be provided by an individual approved to provide pediatric CPR instruction.

(c) The Pediatric CPR training must:

(1) cover CPR techniques for infants and children and the treatment of obstructed airways;

(2) include instruction, hands-on practice, and an in-person, observed skills assessment under the direct supervision of a CPR instructor; and

(3) be developed by the American Heart Association, the American Red Cross, or another organization that uses nationally recognized, evidence-based guidelines for CPR.

(d) Pediatric CPR training must be repeated at least once every second calendar year.

(e) Pediatric CPR training in this subdivision must not be used to meet in-service training requirements under subdivision 7.

Subd. 5. **Sudden unexpected infant death ~~and abusive head trauma~~ training.** (a) Before caring for infants, the director, staff persons, substitutes, and unsupervised volunteers must receive training on the standards under section 245A.1435 and on reducing the risk of sudden unexpected infant death during orientation and each calendar year thereafter.

(b) Sudden unexpected infant death reduction training required under this subdivision must be at least one-half hour in length. At a minimum, the training must address the risk factors related to sudden unexpected infant death, means of reducing the risk of sudden unexpected infant death in child care, and license holder communication with parents regarding reducing the risk of sudden unexpected infant death.

(c) Except if completed during orientation, training taken under this subdivision may be used to meet the in-service training requirements under subdivision 7.

Subd. 5a. **Abusive head trauma training.** ~~(a) License holders must document that before staff persons and volunteers care for infants, they are instructed on the standards in section 245A.1435 and receive training on reducing the risk of sudden unexpected infant death. In addition, license holders must document that before staff persons care for infants or children under school age, they receive training on the risk of abusive head trauma from~~

~~shaking infants and young children. The training in this subdivision may be provided as orientation training under subdivision 1 and in-service training under subdivision 7.~~ (a) Before caring for children under school age, the director, staff persons, substitutes, and unsupervised volunteers must receive training on the risk of abusive head trauma during orientation and each calendar year thereafter.

~~(b) Sudden unexpected infant death reduction training required under this subdivision must be at least one-half hour in length and must be completed at least once every year. At a minimum, the training must address the risk factors related to sudden unexpected infant death, means of reducing the risk of sudden unexpected infant death in child care, and license holder communication with parents regarding reducing the risk of sudden unexpected infant death.~~

~~(c)~~ (b) Abusive head trauma training under this subdivision must be at least one-half hour in length ~~and must be completed at least once every year~~. At a minimum, the training must address the risk factors related to shaking infants and young children, means to reduce the risk of abusive head trauma in child care, and license holder communication with parents regarding reducing the risk of abusive head trauma.

(c) Except if completed during orientation, training taken under this subdivision may be used to meet the in-service training requirements under subdivision 7.

(d) The commissioner shall make available for viewing a video presentation on the dangers associated with shaking infants and young children, which may be used in conjunction with the annual training required under paragraph ~~(c)~~ (a).

Subd. 6. **Child passenger restraint systems~~; training requirement~~.** ~~(a) A license holder must comply with all seat belt and child passenger restraint system requirements under section 169.685. (b) Child care centers that serve a child or children under nine years of age must document training that fulfills the requirements in this subdivision.~~

~~(1)~~ (a) Before a license holder transports a child or children under age ~~nine~~ eight in a motor vehicle, the person placing the child or children in a passenger restraint must satisfactorily complete training on the proper use and installation of child restraint systems in motor vehicles. ~~Training completed under this subdivision may be used to meet orientation training under subdivision 1 and in-service training under subdivision 7.~~

~~(2)~~ (b) Training required under this subdivision must be ~~at least one hour in length, completed at orientation, and~~ repeated at least once every five years. At a minimum, the training must address the proper use of child restraint systems based on the child's size,

weight, and age, and the proper installation of a car seat or booster seat in the motor vehicle used by the license holder to transport the child or children.

~~(3)~~ (c) Training required under this subdivision must be provided by individuals who are certified and approved by the Department of Public Safety, Office of Traffic Safety. License holders may obtain a list of certified and approved trainers through the Department of Public Safety website or by contacting the agency.

~~(4)~~ (d) Child care providers that only transport school-age children as defined in section 245A.02, subdivision 16, in child care buses as defined in section 169.448, subdivision 1, paragraph (e), are exempt from this subdivision.

(e) Training completed under this subdivision may be used to meet in-service training requirements under subdivision 7. Training completed within the previous five years is transferable upon a staff person's change in employment to another child care center.

Subd. 7. **In-service.** (a) A license holder must ensure that the center director ~~and all staff who have direct contact with a child complete annual in-service training. In-service training requirements must be met by a staff person's participation in the following training areas:~~, staff persons, substitutes, and unsupervised volunteers complete in-service training each calendar year.

(b) The center director and staff persons who work more than 20 hours per week must complete 24 hours of in-service training each calendar year. Staff persons who work 20 hours or less per week must complete 12 hours of in-service training each calendar year. Substitutes and unsupervised volunteers must complete the requirements of paragraphs (e) to (h) and do not otherwise have a minimum number of hours of training to complete.

(c) The number of in-service training hours may be prorated for individuals not employed for an entire year.

(d) Each year, in-service training must include:

(1) the center's procedures for maintaining health and safety according to section 245A.41 and Minnesota Rules, part 9503.0140, and handling emergencies and accidents according to Minnesota Rules, part 9503.0110;

(2) the reporting responsibilities under section 626.556 and Minnesota Rules, part 9503.0130;

(3) at least one-half hour of training on the standards under section 245A.1435 and on reducing the risk of sudden unexpected infant death as required under subdivision 5, if applicable; and

(4) at least one-half hour of training on the risk of abusive head trauma from shaking infants and young children as required under subdivision 5a, if applicable.

(e) Each year, or when a change is made, whichever is more frequent, in-service training must be provided on: (1) the center's risk reduction plan under section 245A.66, subdivision 2; and (2) a child's individual child care program plan as required under Minnesota Rules, part 9503.0065, subpart 3.

(f) At least once every two calendar years, the in-service training must include:

(1) child development and learning training under subdivision 2;

(2) pediatric first aid that meets the requirements of subdivision 3;

(3) pediatric cardiopulmonary resuscitation training that meets the requirements of subdivision 4;

(4) cultural dynamics training to increase awareness of cultural differences; and

(5) disabilities training to increase awareness of differing abilities of children.

(g) At least once every five years, in-service training must include child passenger restraint training that meets the requirements of subdivision 6, if applicable.

(h) The remaining hours of the in-service training requirement must be met by completing training in the following content areas of the Minnesota Knowledge and Competency Framework:

(1) Content area I: child development and learning;

(2) Content area II: developmentally appropriate learning experiences;

(3) Content area III: relationships with families;

(4) Content area IV: assessment, evaluation, and individualization;

(5) Content area V: historical and contemporary development of early childhood education;

(6) Content area VI: professionalism; ~~and~~

(7) Content area VII: health, safety, and nutrition; and

(8) Content area VIII: application through clinical experiences.

~~(b)~~ (i) For purposes of this subdivision, the following terms have the meanings given them.

(1) "Child development and learning training" ~~has the meaning given it in subdivision 2, paragraph (a).~~ means training in understanding how children develop physically, cognitively, emotionally, and socially and learn as part of the children's family, culture, and community.

(2) "Developmentally appropriate learning experiences" means creating positive learning experiences, promoting cognitive development, promoting social and emotional development, promoting physical development, and promoting creative development.

(3) "Relationships with families" means training on building a positive, respectful relationship with the child's family.

(4) "Assessment, evaluation, and individualization" means training in observing, recording, and assessing development; assessing and using information to plan; and assessing and using information to enhance and maintain program quality.

(5) "Historical and contemporary development of early childhood education" means training in past and current practices in early childhood education and how current events and issues affect children, families, and programs.

(6) "Professionalism" means training in knowledge, skills, and abilities that promote ongoing professional development.

(7) "Health, safety, and nutrition" means training in establishing health practices, ensuring safety, and providing healthy nutrition.

(8) "Application through clinical experiences" means clinical experiences in which a person applies effective teaching practices using a range of educational programming models.

~~(c) The director and all program staff persons must annually complete a number of hours of in-service training equal to at least two percent of the hours for which the director or program staff person is annually paid, unless one of the following is applicable.~~

~~(1) A teacher at a child care center must complete one percent of working hours of in-service training annually if the teacher:~~

~~(i) possesses a baccalaureate or master's degree in early childhood education or school-age care;~~

~~(ii) is licensed in Minnesota as a prekindergarten teacher, an early childhood educator, a kindergarten to sixth grade teacher with a prekindergarten specialty, an early childhood special education teacher, or an elementary teacher with a kindergarten endorsement; or~~

~~(iii) possesses a baccalaureate degree with a Montessori certificate.~~

~~(2) A teacher or assistant teacher at a child care center must complete one and one-half percent of working hours of in-service training annually if the individual is:~~

~~(i) a registered nurse or licensed practical nurse with experience working with infants;~~

~~(ii) possesses a Montessori certificate, a technical college certificate in early childhood development, or a child development associate certificate; or~~

~~(iii) possesses an associate of arts degree in early childhood education, a baccalaureate degree in child development, or a technical college diploma in early childhood development.~~

~~(d) The number of required training hours may be prorated for individuals not employed full time or for an entire year.~~

~~(e) The annual in-service training must be completed within the calendar year for which it was required. In-service training completed by staff persons is transferable upon a staff person's change in employment to another child care program.~~

~~(f)~~ (j) The license holder must ensure that~~, when a staff person completes in-service training, the training is documented in the staff person's personnel record. The documentation must include the date training was completed, the goal of the training and topics covered, trainer's name and organizational affiliation, trainer's signed statement that training was successfully completed,~~ documentation, as required in subdivision 10, includes the number of total training hours required to be completed, name of the training, the Minnesota Knowledge and Competency Framework content area, number of hours completed, and the director's approval of the training.

(k) In-service training completed by a staff person that is not specific to that child care center is transferable upon a staff person's change in employment to another child care program.

~~Subd. 8. **Cultural dynamics and disabilities training for child care providers.** (a) The training required of licensed child care center staff must include training in the cultural dynamics of early childhood development and child care. The cultural dynamics and disabilities training and skills development of child care providers must be designed to achieve outcomes for providers of child care that include, but are not limited to:~~

~~(1) an understanding and support of the importance of culture and differences in ability in children's identity development;~~

~~(2) understanding the importance of awareness of cultural differences and similarities in working with children and their families;~~

~~(3) understanding and support of the needs of families and children with differences in ability;~~

~~(4) developing skills to help children develop unbiased attitudes about cultural differences and differences in ability;~~

~~(5) developing skills in culturally appropriate caregiving; and~~

~~(6) developing skills in appropriate caregiving for children of different abilities.~~

~~(b) Curriculum for cultural dynamics and disability training shall be approved by the commissioner.~~

~~(c) The commissioner shall amend current rules relating to the training of the licensed child care center staff to require cultural dynamics training. Timelines established in the rule amendments for complying with the cultural dynamics training requirements must be based on the commissioner's determination that curriculum materials and trainers are available statewide.~~

~~(d) For programs caring for children with special needs, the license holder shall ensure that any additional staff training required by the child's individual child care program plan required under Minnesota Rules, part 9503.0065, subpart 3, is provided.~~

~~Subd. 9. **Ongoing health and safety training.** A staff person's orientation training on maintaining health and safety and handling emergencies and accidents, as required in subdivision 1, must be repeated at least once each calendar year by each staff person. The completion of the annual training must be documented in the staff person's personnel record.~~

Subd. 10. **Documentation.** All training must be documented and maintained on site in each personnel record. In addition to any requirements for each training provided in this section, documentation for each staff person must include the staff person's first date of direct contact and first date of unsupervised contact with a child in care.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 10. Minnesota Statutes 2018, section 245A.41, is amended to read:

245A.41 CHILD CARE CENTER HEALTH AND SAFETY REQUIREMENTS.

Subdivision 1. **Allergy prevention and response.** (a) Before admitting a child for care, the license holder must obtain documentation of any known allergy from the child's parent or legal guardian or the child's source of medical care. If a child has a known allergy, the license holder must maintain current information about the allergy in the child's record and develop an individual child care program plan as specified in Minnesota Rules, part

9503.0065, subpart 3. The individual child care program plan must include but not be limited to a description of the allergy, specific triggers, avoidance techniques, symptoms of an allergic reaction, and procedures for responding to an allergic reaction, including medication, dosages, and a doctor's contact information.

(b) The license holder must ensure that each staff person who is responsible for carrying out the individual child care program plan review and follow the plan. Documentation of a staff person's review must be kept on site.

(c) At least ~~annually~~ once each calendar year or following any changes made to allergy-related information in the child's record, the license holder must update the child's individual child care program plan and inform each staff person who is responsible for carrying out the individual child care program plan of the change. The license holder must keep on site documentation that a staff person was informed of a change.

(d) A child's allergy information must be available at all times including on site, when on field trips, or during transportation. A child's food allergy information must be readily available to a staff person in the area where food is prepared and served to the child.

(e) The license holder must contact the child's parent or legal guardian as soon as possible in any instance of exposure or allergic reaction that requires medication or medical intervention. The license holder must call emergency medical services when epinephrine is administered to a child in the license holder's care.

Subd. 2. **Handling and disposal of bodily fluids.** The licensed child care center must comply with the following procedures for safely handling and disposing of bodily fluids:

(1) surfaces that come in contact with potentially infectious bodily fluids, including blood and vomit, must be cleaned and disinfected according to Minnesota Rules, part 9503.0005, subpart 11;

(2) blood-contaminated material must be disposed of in a plastic bag with a secure tie;

(3) sharp items used for a child with special care needs must be disposed of in a "sharps container." The sharps container must be stored out of reach of a child;

(4) the license holder must have the following bodily fluid disposal supplies in the center: disposable gloves, disposal bags, and eye protection; and

(5) the license holder must ensure that each staff person ~~is trained on~~ follows universal precautions to reduce the risk of spreading infectious disease. ~~A staff person's completion of the training must be documented in the staff person's personnel record.~~

Subd. 3. **Emergency preparedness.** (a) ~~No later than September 30, 2017,~~ A licensed child care center must have a written emergency plan for emergencies that require evacuation, sheltering, or other protection of a child, such as fire, natural disaster, intruder, or other threatening situation that may pose a health or safety hazard to a child. The plan must be written on a form developed by the commissioner and must include:

(1) procedures for an evacuation, relocation, shelter-in-place, or lockdown;

(2) a designated relocation site and evacuation route;

(3) procedures for notifying a child's parent or legal guardian of the evacuation, relocation, shelter-in-place, or lockdown, including procedures for reunification with families;

(4) accommodations for a child with a disability or a chronic medical condition;

(5) procedures for storing a child's medically necessary medicine that facilitates easy removal during an evacuation or relocation;

(6) procedures for continuing operations in the period during and after a crisis; ~~and~~

(7) procedures for communicating with local emergency management officials, law enforcement officials, or other appropriate state or local authorities; and

(8) accommodations for infants and toddlers.

~~(b) The license holder must train staff persons on the emergency plan at orientation, when changes are made to the plan, and at least once each calendar year. Training must be documented in each staff person's personnel file.~~

~~(c)~~ (b) The license holder must conduct drills according to the requirements in Minnesota Rules, part 9503.0110, subpart 3. The date and time of the drills must be documented.

~~(d)~~ (c) The license holder must review and update the emergency plan ~~annually~~ at least once each calendar year. Staff must be informed of any changes made to the emergency plan. Documentation of the ~~annual~~ yearly emergency plan review and staff notification of changes shall be maintained in the program's administrative records.

~~(e)~~ (d) The license holder must include the emergency plan in the program's policies and procedures as specified under section 245A.04, subdivision 14. ~~The license holder must provide a physical or electronic copy of the emergency plan to the child's parent or legal guardian upon enrollment.~~

~~(f)~~ (e) The relocation site and evacuation route must be posted in a visible place as part of the written procedures for emergencies and accidents in Minnesota Rules, part 9503.0140, subpart 21.

Subd. 4. **Child passenger restraint requirements.** A license holder must comply with all seat belt and child passenger restraint system requirements under section 169.685.

Subd. 5. **Telephone requirement in licensed child care centers.** (a) A working telephone which is capable of making outgoing calls and receiving incoming calls must be located within the licensed child care center at all times. Staff must have access to a working telephone while providing care and supervision to children in care, even if the care occurs outside of the child care facility. A license holder may use a cellular telephone to meet the requirements of this subdivision.

(b) If a cellular telephone is used to satisfy the requirements of this subdivision, the cellular telephone must be accessible to staff, be stored in a centrally located area when not in use, and remain charged at all times.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 11. Minnesota Statutes 2018, section 245A.50, is amended to read:

245A.50 FAMILY CHILD CARE TRAINING REQUIREMENTS.

Subdivision 1. **Initial training.** (a) License holders, caregivers, ~~and~~ substitutes, emergency substitutes, and helpers must comply with the training requirements in this section.

~~(b) Helpers who assist with care on a regular basis must complete six hours of training within one year after the date of initial employment.~~

(b) The license holder, before initial licensure, and a caregiver, before caring for a child, must complete:

(1) the six-hour Supervising for Safety for Family Child Care course developed by the commissioner;

(2) a two-hour course in Knowledge and Competency Area I: Child Development and Learning, as required by subdivision 2;

(3) a two-hour course in behavior guidance that may be fulfilled by completing any course in Knowledge and Competency Area II-C: Promoting Social and Emotional Development, as required by subdivision 2;

(4) pediatric first aid, as required by subdivision 3;

(5) pediatric cardiopulmonary resuscitation, as required by subdivision 4;

(6) if applicable, training in reducing the risk of sudden unexpected infant death and abusive head trauma as required by subdivision 5; and

(7) if applicable, training in child passenger restraint as required by subdivision 6.

The license holder or caregiver may take one four-hour course that covers both clauses (2) and (3) to meet the requirements of this subdivision.

(c) Before caring for a child, each substitute and emergency substitute must complete:

(1) the four-hour Basics of Licensed Family Child Care for Substitutes course developed by the commissioner;

(2) pediatric first aid, as required by subdivision 3;

(3) pediatric cardiopulmonary resuscitation, as required by subdivision 4; and

(4) if applicable, training in reducing the risk of sudden unexpected infant death and abusive head trauma as required by subdivision 5.

(d) Each helper must complete:

(1) if applicable, before assisting with the care of a child under school age, training in reducing the risk of sudden unexpected infant death and abusive head trauma, as required by subdivision 5; and

(2) within 90 days of the start of employment, the one-hour Child Development for Helpers course developed by the commissioner.

(e) Before caring for a child or assisting in the care of a child, the license holder must train each caregiver, substitute, and emergency substitute on:

(1) the emergency plan required under section 245A.51, subdivision 3, paragraph (b);

(2) allergy prevention and response required under section 245A.51, subdivision 1, paragraph (b); and

(3) the drug and alcohol policy required under section 245A.04, subdivision 1, paragraph (c).

~~(e)~~ (f) Training requirements established under this section that must be completed prior to initial licensure must be satisfied only by a newly licensed child care provider or by a child care provider who has not held an active child care license in Minnesota in the previous 12 months. A child care provider who relocates within the state or who voluntarily cancels a license or allows the license to lapse for a period of less than 12 months and who seeks reinstatement of the lapsed or canceled license within 12 months of the lapse or cancellation

must satisfy the annual, ongoing training requirements, and is not required to satisfy the training requirements that must be completed prior to initial licensure.

Subd. 1a. **Definitions.** (a) For the purposes of this section, the following terms have the meanings given them.

(b) "Basics of Family Child Care for Substitutes" means a class developed by the commissioner that includes the following topics: prevention and control of infectious diseases; administering medication; preventing and responding to allergies; ensuring building and physical premise safety; handling and storing biological contaminants; preventing and reporting abuse and child maltreatment; emergency preparedness; and child development.

(c) "Caregiver" means an adult other than the license holder who supervises children for a cumulative total of 300 or more hours in any calendar year.

(d) "Emergency substitute" means an adult who assumes the responsibility of a provider for a cumulative total of not more than 50 hours in a calendar year.

(e) "Helper" means a minor, ages 13 through 17, who assists in the care of the children.

(f) "Substitute" means an adult who assumes the responsibility of a provider for a cumulative total of not more than 300 hours in any calendar year.

Subd. 2. **Child development and learning and behavior guidance training.** (a) ~~For purposes of family and group family child care,~~ The license holder and each ~~adult~~ caregiver ~~who provides care in the licensed setting for more than 30 days in any 12-month period~~ shall complete ~~and document~~ at least four hours of child growth and learning and behavior guidance training prior to initial licensure, and before caring for children. ~~For purposes of this subdivision, "child development and learning training" means training in understanding how children develop physically, cognitively, emotionally, and socially and learn as part of the children's family, culture, and community. "Behavior guidance training" means training in the understanding of the functions of child behavior and strategies for managing challenging situations. At least two hours of child development and learning or behavior guidance training must be repeated annually. Training curriculum shall be developed or approved by the commissioner of human services.~~

(b) Notwithstanding paragraph (a), individuals are exempt from this requirement if they:

(1) have taken a three-credit course on early childhood development within the past five years;

(2) have received a baccalaureate or master's degree in early childhood education or school-age child care within the past five years;

(3) are licensed in Minnesota as a prekindergarten teacher, an early childhood educator, a kindergarten to grade 6 teacher with a prekindergarten specialty, an early childhood special education teacher, or an elementary teacher with a kindergarten endorsement; or

(4) have received a baccalaureate degree with a Montessori certificate within the past five years.

(c) The license holder and each caregiver must complete at least two hours of child development training annually that may be fulfilled by completing any course in Knowledge and Competency Area I: Child Development and Learning; or behavior guidance training that may be fulfilled by completing any course in Knowledge and Competency Area II-C: Promoting Social and Emotional Development. The commissioner shall develop or approve training curriculum.

Subd. 3. **First aid.** (a) ~~When children are present in a family child care home governed by Minnesota Rules, parts 9502.0315 to 9502.0445, at least one staff person must be present in the home who has been trained in first aid.~~ The license holder must complete pediatric first aid training before licensure and each caregiver, substitute, and emergency substitute must complete pediatric first aid training before caring for children. The first aid training must have been provided by an individual approved to provide first aid instruction. First aid training may be less than eight hours and persons qualified to provide first aid training include individuals approved as first aid instructors. ~~First aid training must be repeated every two years.~~

(b) ~~A family child care provider is exempt from the first aid training requirements under this subdivision related to any substitute caregiver who provides less than 30 hours of care during any 12-month period.~~ The license holder, each caregiver, substitute, and emergency substitute must complete additional pediatric first aid training every two years.

(c) Video training reviewed and approved by the county licensing agency satisfies the training requirement of this subdivision.

Subd. 4. **Cardiopulmonary resuscitation.** (a) ~~When children are present in a family child care home governed by Minnesota Rules, parts 9502.0315 to 9502.0445, at least one caregiver must be present in the home who has been trained in cardiopulmonary resuscitation (CPR), including CPR techniques for infants and children, and in the treatment of obstructed airways. The CPR training must have been provided by an individual approved to provide CPR instruction, must be repeated at least once every two years, and must be documented in the caregiver's records.~~ The family child care license holder must complete pediatric cardiopulmonary resuscitation (CPR) training prior to licensure. Caregivers, substitutes,

and emergency substitutes must complete pediatric CPR training prior to caring for children. Training that has been completed in the previous two years fulfills this requirement.

(b) ~~A family child care provider is exempt from the CPR training requirement in this subdivision related to any substitute caregiver who provides less than 30 hours of care during any 12-month period.~~ The CPR training must be provided by an individual approved to provide CPR instruction.

(c) ~~Persons providing CPR training must use CPR training that has been developed:~~ The Pediatric CPR training must:

~~(1) by the American Heart Association or the American Red Cross and incorporates psychomotor skills to support the instruction; or~~

~~(2) using nationally recognized, evidence-based guidelines for CPR training and incorporates psychomotor skills to support the instruction.~~

(1) cover CPR techniques for infants and children and the treatment of obstructed airways;

(2) include instruction, hands-on practice, and an in-person observed skills assessment under the direct supervision of a CPR instructor; and

(3) be developed by the American Heart Association, the American Red Cross, or another organization that uses nationally recognized, evidence-based guidelines for CPR.

(d) License holders, caregivers, substitutes, and emergency substitutes must complete pediatric CPR training at least once every two years.

Subd. 5. **Sudden unexpected infant death and abusive head trauma training.** (a) The license holder must complete training on reducing the risk of sudden unexpected infant death prior to caring for infants. License holders must ~~document~~ ensure that before ~~staff persons,~~ caregivers, substitutes, emergency substitutes, and helpers assist in the care of infants, they are instructed on the standards in section 245A.1435 and receive training on reducing the risk of sudden unexpected infant death.

(b) The license holder must complete training on reducing the risk of abusive head trauma, prior to caring for infants and children under school age. In addition, license holders must ~~document~~ ensure that before ~~staff persons,~~ caregivers, substitutes, emergency substitutes, and helpers assist in the care of infants and children under school age, they receive training on reducing the risk of abusive head trauma ~~from shaking infants and young children~~. ~~The training in this subdivision may be provided as initial training under subdivision 1 or ongoing annual training under subdivision 7.~~

~~(b)~~ (c) Sudden unexpected infant death reduction training required under this subdivision must, at a minimum, address the risk factors related to sudden unexpected infant death, means of reducing the risk of sudden unexpected infant death in child care, and license holder communication with parents regarding reducing the risk of sudden unexpected infant death.

~~(c)~~ (d) Abusive head trauma training required under this subdivision must, at a minimum, address the risk factors related to shaking infants and young children, means of reducing the risk of abusive head trauma in child care, and license holder communication with parents regarding reducing the risk of abusive head trauma.

~~(d)~~ (e) Training for family and group family child care providers must be developed by the commissioner ~~in conjunction with the Minnesota Sudden Infant Death Center~~ and approved by ~~the Minnesota Center for Professional Development~~ Achieve - The MN Center for Professional Development. Sudden unexpected infant death reduction training and abusive head trauma training may be provided in a single course of no more than two hours in length.

~~(e)~~ (f) Sudden unexpected infant death reduction training and abusive head trauma training required under this subdivision must be completed in person or as allowed under subdivision 10, clause (1) or (2), at least once every two years. On the years when the license holder ~~is~~, caregiver, substitute, and helper are not receiving training in person or as allowed under subdivision 10, clause (1) or (2), the license holder, caregiver, substitute, and helper must receive sudden unexpected infant death reduction training and abusive head trauma training through a video of no more than one hour in length. The video must be developed or approved by the commissioner.

~~(f)~~ (g) An individual who is related to the license holder as defined in section 245A.02, subdivision 13, and who is involved only in the care of the license holder's own infant or child under school age and who is not designated to be a caregiver, helper, or substitute, as defined in Minnesota Rules, part 9502.0315, for the licensed program, is exempt from the sudden unexpected infant death and abusive head trauma training.

Subd. 6. **Child passenger restraint systems; training requirement.** ~~(a) A license holder must comply with all seat belt and child passenger restraint system requirements under section 169.685.~~

~~(b) Family and group family child care programs licensed by the Department of Human Services that serve a child or children under nine years of age must document training that fulfills the requirements in this subdivision.~~

(a)(1) Before a license holder, ~~staff person, caregiver, or helper~~ caregiver, substitute, or emergency substitute transports a child or children under age ~~nine~~ eight in a motor vehicle, the person placing the child or children in a passenger restraint must satisfactorily complete training on the proper use and installation of child restraint systems in motor vehicles. Training completed under this subdivision may be used to meet initial training under subdivision 1 or ongoing training under subdivision 7.

(2) Training required under this subdivision must be ~~at least one hour in length, completed at initial training, and~~ repeated at least once every five years.

(3) At a minimum, the training must address the proper use of child restraint systems based on the child's size, weight, and age, and the proper installation of a car seat or booster seat in the motor vehicle used by the license holder to transport the child or children.

~~(3)~~ (4) Training under this subdivision must be provided by individuals who are certified and approved by the Department of Public Safety, Office of Traffic Safety. License holders may obtain a list of certified and approved trainers through the Department of Public Safety website or by contacting the agency.

~~(c)~~ (b) Child care providers that only transport school-age children as defined in section 245A.02, subdivision 19, paragraph (f), in child care buses as defined in section 169.448, subdivision 1, paragraph (e), are exempt from this subdivision.

Subd. 7. **Ongoing training requirements for family and group family child care license holders and caregivers.** ~~For purposes of family and group family child care,~~ (a) The license holder and each primary caregiver must complete 16 hours of ongoing training each year. ~~For purposes of this subdivision, a primary caregiver is an adult caregiver who provides services in the licensed setting for more than 30 days in any 12-month period. Repeat of topical training requirements in subdivisions 2 to 8 shall count toward the annual 16-hour training requirement.~~

(b) The license holder and caregiver must annually complete ongoing training as follows:

(1) as required by subdivision 2, a two-hour course in: child development that may be fulfilled by any course in Knowledge and Competency Area I: Child Development and Learning; or behavior guidance that may be fulfilled by any course in Knowledge and Competency Area II-C: Promoting Social and Emotional Development;

(2) a two-hour course in active supervision that may be fulfilled by any course in: Knowledge and Competency Area VII-A: Establishing Healthy Practices; or Knowledge and Competency Area VII-B: Ensuring Safety; and

(3) if applicable, ongoing training in reducing the risk of sudden unexpected infant death and abusive head trauma, as required under subdivision 5.

(c) At least once every two years, the license holder and caregiver must complete ongoing training as follows:

(1) training in pediatric first aid as required under subdivision 3;

(2) training in pediatric CPR as required under subdivision 4; and

(3) a two-hour course on accommodating children with disabilities or on cultural dynamics that may be fulfilled by completing any course in Knowledge and Competency Area III: Relationships with Families.

(d) At least once every five years, the license holder and caregiver must complete ongoing training as follows:

(1) the two-hour courses Health and Safety I and Health and Safety II; and

(2) if applicable, ongoing training in child passenger restraint, as required under subdivision 6.

(e) Additional ongoing training subjects to meet the annual 16-hour training requirement must be selected from ~~the following areas~~ training in the following content areas of the Minnesota Knowledge and Competency Framework:

(1) Content area I: child development and learning, including training ~~under subdivision 2, paragraph (a)~~ in understanding how children develop physically, cognitively, emotionally, and socially; and learn as part of the childrens' family, culture, and community;

(2) Content area II: developmentally appropriate learning experiences, including training in creating positive learning experiences, promoting cognitive development, promoting social and emotional development, promoting physical development, promoting creative development; and behavior guidance;

(3) Content area III: relationships with families, including training in building a positive, respectful relationship with the child's family;

(4) Content area IV: assessment, evaluation, and individualization, including training in observing, recording, and assessing development; assessing and using information to plan; and assessing and using information to enhance and maintain program quality;

(5) Content area V: historical and contemporary development of early childhood education, including training in past and current practices in early childhood education and how current events and issues affect children, families, and programs;

(6) Content area VI: professionalism, including training in knowledge, skills, and abilities that promote ongoing professional development; and

(7) Content area VII: health, safety, and nutrition, including training in establishing healthy practices; ensuring safety; and providing healthy nutrition.

Subd. 8. **~~Other required training requirements~~ Ongoing training requirements for substitutes, emergency substitutes, and helpers.** ~~(a) The training required of family and group family child care providers and staff must include training in the cultural dynamics of early childhood development and child care. The cultural dynamics and disabilities training and skills development of child care providers must be designed to achieve outcomes for providers of child care that include, but are not limited to:~~

~~(1) an understanding and support of the importance of culture and differences in ability in children's identity development;~~

~~(2) understanding the importance of awareness of cultural differences and similarities in working with children and their families;~~

~~(3) understanding and support of the needs of families and children with differences in ability;~~

~~(4) developing skills to help children develop unbiased attitudes about cultural differences and differences in ability;~~

~~(5) developing skills in culturally appropriate caregiving; and~~

~~(6) developing skills in appropriate caregiving for children of different abilities.~~

~~The commissioner shall approve the curriculum for cultural dynamics and disability training.~~

~~(b) The provider must meet the training requirement in section 245A.14, subdivision 11, paragraph (a), clause (4), to be eligible to allow a child cared for at the family child care or group family child care home to use the swimming pool located at the home.~~

(a) Each substitute and emergency substitute must complete ongoing training on the following schedule:

(1) annually, if applicable, training in reducing the risk of sudden unexpected infant death and abusive head trauma as required under subdivision 5;

(2) at least once every two years: (i) training in pediatric first aid as required under subdivision 3; (ii) training in pediatric CPR as required under subdivision 4; and (iii) the four-hour Basics of Licensed Family Child Care for Substitutes course; and

(3) at least once every five years, if applicable, training in child passenger restraints, as required under subdivision 6.

(b) Each helper must complete training on the following schedule:

(1) annually, if applicable, training in reducing the risk of sudden unexpected infant death and abusive head trauma as required under subdivision 5; and

(2) at least once every two years: (i) the one-hour course Basics of Child Development for Helpers; or (ii) any course in Knowledge and Competency Area I: Child Development and Learning.

~~Subd. 9. **Supervising for safety; training requirement.** (a) Before initial licensure and before caring for a child, all family child care license holders and each adult caregiver who provides care in the licensed family child care home for more than 30 days in any 12-month period shall complete and document the completion of the six-hour Supervising for Safety for Family Child Care course developed by the commissioner.~~

~~(b) The family child care license holder and each adult caregiver who provides care in the licensed family child care home for more than 30 days in any 12-month period shall complete and document:~~

~~(1) the annual completion of a two-hour active supervision course developed by the commissioner; and~~

~~(2) the completion at least once every five years of the two-hour courses Health and Safety I and Health and Safety II. A license holder's or adult caregiver's completion of either training in a given year meets the annual active supervision training requirement in clause (1).~~

Subd. 10. **Approved training.** County licensing staff must accept training approved by ~~the Minnesota Center for Professional Development~~ Achieve - the MN Center for Professional Development, including:

(1) face-to-face or classroom training;

(2) online training; and

(3) relationship-based professional development, such as mentoring, coaching, and consulting.

Subd. 11. **Provider training.** New and increased training requirements under this section must not be imposed on providers until the commissioner establishes statewide accessibility to the required provider training.

Subd. 12. **Documentation.** The license holder must document the date of a completed training required by this section for the license holder, each caregiver, substitute, emergency substitute, and helper.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 12. Minnesota Statutes 2018, section 245A.51, subdivision 3, is amended to read:

Subd. 3. **Emergency preparedness plan.** (a) ~~No later than September 30, 2017,~~ A licensed family child care provider must have a written emergency preparedness plan for emergencies that require evacuation, sheltering, or other protection of children, such as fire, natural disaster, intruder, or other threatening situation that may pose a health or safety hazard to children. The plan must be written on a form developed by the commissioner and updated at least annually. The plan must include:

(1) procedures for an evacuation, relocation, shelter-in-place, or lockdown;

(2) a designated relocation site and evacuation route;

(3) procedures for notifying a child's parent or legal guardian of the evacuation, shelter-in-place, or lockdown, including procedures for reunification with families;

(4) accommodations for a child with a disability or a chronic medical condition;

(5) procedures for storing a child's medically necessary medicine that facilitate easy removal during an evacuation or relocation;

(6) procedures for continuing operations in the period during and after a crisis; ~~and~~

(7) procedures for communicating with local emergency management officials, law enforcement officials, or other appropriate state or local authorities; and

(8) accommodations for infants and toddlers.

(b) The license holder must train caregivers before the caregiver provides care and at least annually on the emergency preparedness plan and document completion of this training.

(c) The license holder must conduct drills according to the requirements in Minnesota Rules, part 9502.0435, subpart 8. The date and time of the drills must be documented.

~~(d) The license holder must have the emergency preparedness plan available for review and posted in a prominent location. The license holder must provide a physical or electronic copy of the plan to the child's parent or legal guardian upon enrollment.~~

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 13. Minnesota Statutes 2018, section 245A.51, is amended by adding a subdivision to read:

Subd. 4. **Transporting children.** A license holder must comply with all seat belt and child passenger restraint system requirements under section 169.685.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 14. Minnesota Statutes 2018, section 245A.51, is amended by adding a subdivision to read:

Subd. 5. **Telephone requirement.** Notwithstanding Minnesota Rules, part 9502.0435, subpart 8, item B, a license holder is not required to post a list of emergency numbers. A license holder may use a cellular telephone to meet the requirements of Minnesota Rules, part 9502.0435, subpart 8, if the cellular telephone remains charged at all times.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 15. **[245A.52] FAMILY CHILD CARE PHYSICAL SPACE REQUIREMENTS.**

Subdivision 1. **Means of escape.** (a) (1) At least one emergency escape route separate from the main exit from the space must be available in each room used for sleeping by anyone receiving licensed care, and (2) a basement used for child care. One means of escape must be a stairway or door leading to the floor of exit discharge. The other must be a door or window leading directly outside. A window used as an emergency escape route must be openable without special knowledge.

(b) In homes with construction that began before May 2, 2016, the interior of the window leading directly outside must have a net clear opening area of not less than 4.5 square feet or 648 square inches and have minimum clear opening dimensions of 20 inches wide and 20 inches high. The opening must be no higher than 48 inches from the floor. The height to the window may be measured from a platform if a platform is located below the window.

(c) In homes with construction that began on or after May 2, 2016, the interior of the window leading directly outside must have minimum clear opening dimensions of 20 inches wide and 24 inches high. The net clear opening dimensions shall be the result of normal operation of the opening. The opening must be no higher than 44 inches from the floor.

(d) The commissioner may establish additional requirements that are dependent on the distance of the openings from the ground outside the window including: (1) windows or other openings with a sill height not more than 44 inches above or below the finished ground level adjacent to the opening (grade-floor emergency escape and rescue openings) must

have a minimum opening of five square feet; and (2) non-grade floor emergency escape and rescue openings must have a minimum opening of 5.7 square feet.

Subd. 2. **Door to attached garage.** Notwithstanding Minnesota Rules, part 9502.0425, subpart 5, day care residences with an attached garage are not required to have a self-closing door to the residence. The door to the residence may be a steel insulated door if the door is at least 1-3/8 inches thick.

Subd. 3. **Heating and venting systems.** Notwithstanding Minnesota Rules, part 9502.0425, subpart 7, items that can be ignited and support combustion, including but not limited to plastic, fabric, and wood products must not be located within 18 inches of a gas or fuel-oil heater or furnace. If a license holder produces manufacturer instructions listing a smaller distance, then the manufacturer instructions control the distance combustible items must be from gas, fuel-oil, or solid-fuel burning heaters or furnaces.

Subd. 4. **Fire extinguisher.** A portable, operational, multipurpose, dry chemical fire extinguisher with a minimum 2 A 10 BC rating must be located in or near the kitchen and cooking areas of the residence at all times. The fire extinguisher must be serviced annually by a qualified inspector. All caregivers must know how to properly use the fire extinguisher.

Subd. 5. **Carbon monoxide and smoke alarms.** (a) All homes must have an approved and operational carbon monoxide alarm installed within ten feet of each room used for sleeping children in care.

(b) Smoke alarms that have been listed by the Underwriter Laboratory must be properly installed and maintained on all levels including basements, but not including crawl spaces and uninhabitable attics, and in hallways outside rooms used for sleeping children in care.

(c) In homes with construction that began on or after May 2, 2016, smoke alarms must be installed and maintained in each room used for sleeping children in care.

Subd. 6. **Updates.** After readoption of the Minnesota State Fire Code, the fire marshal must notify the commissioner of any changes that conflict with this section and Minnesota Rules, chapter 9502. The state fire marshal must identify necessary statutory changes to align statutes with the revised code. The commissioner must recommend updates to sections of chapter 245A that are derived from the Minnesota State Fire Code in the legislative session following readoption of the code.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 16. **[245A.53] SUPERVISION AND USE OF SUBSTITUTES.**

Notwithstanding Minnesota Rules, part 9502.0365, subpart 5, the use of a substitute caregiver must be limited to a cumulative total of not more than 300 hours in a calendar year and a provider may use an additional 50 hours of care provided by an emergency substitute, as defined in section 245A.50, subdivision 1a, in the same calendar year.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 17. Minnesota Statutes 2018, section 245A.66, subdivision 2, is amended to read:

Subd. 2. **Child care centers; risk reduction plan.** (a) Child care centers licensed under this chapter and Minnesota Rules, chapter 9503, must develop a risk reduction plan that identifies the general risks to children served by the child care center. The license holder must establish procedures to minimize identified risks, train staff on the procedures, and annually review the procedures.

(b) The risk reduction plan must include an assessment of risk to children the center serves or intends to serve and identify specific risks based on the outcome of the assessment. The assessment of risk must be based on the following:

(1) an assessment of the risks presented by the physical plant where the licensed services are provided, including an evaluation of the following factors: the condition and design of the facility and its outdoor space, bathrooms, storage areas, and accessibility of medications and cleaning products that are harmful to children when children are not supervised and the existence of areas that are difficult to supervise; and

(2) an assessment of the risks presented by the environment for each facility and for each site, including an evaluation of the following factors: the type of grounds and terrain surrounding the building and the proximity to hazards, busy roads, and publicly accessed businesses.

(c) The risk reduction plan must include a statement of measures that will be taken to minimize the risk of harm presented to children for each risk identified in the assessment required under paragraph (b) related to the physical plant and environment. At a minimum, the stated measures must include the development and implementation of specific policies and procedures or reference to existing policies and procedures that minimize the risks identified.

(d) In addition to any program-specific risks identified in paragraph (b), the plan must include development and implementation of specific policies and procedures or refer to

existing policies and procedures that minimize the risk of harm or injury to children, including:

(1) closing children's fingers in doors, including cabinet doors;

(2) leaving children in the community without supervision;

(3) children leaving the facility without supervision;

(4) caregiver dislocation of children's elbows;

(5) burns from hot food or beverages, whether served to children or being consumed by caregivers, and the devices used to warm food and beverages;

(6) injuries from equipment, such as scissors and glue guns;

(7) sunburn;

(8) feeding children foods to which they are allergic;

(9) children falling from changing tables; and

(10) children accessing dangerous items or chemicals or coming into contact with residue from harmful cleaning products.

(e) The plan shall prohibit the accessibility of hazardous items to children.

(f) The plan must include specific policies and procedures to ensure adequate supervision of children at all times as defined under section 245A.02, subdivision 18, with particular emphasis on:

(1) times when children are transitioned from one area within the facility to another;

(2) nap-time supervision, including infant crib rooms as specified under section 245A.02, subdivision 18, which requires that when an infant is placed in a crib to sleep, supervision occurs when a staff person is within sight or hearing of the infant. When supervision of a crib room is provided by sight or hearing, the center must have a plan to address the other supervision components;

(3) child drop-off and pick-up times;

(4) supervision during outdoor play and on community activities, including but not limited to field trips and neighborhood walks; ~~and~~

(5) supervision of children in hallways~~.~~; and

(6) supervision of school-age children when using the restroom and visiting the child's personal storage space.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 18. Minnesota Statutes 2018, section 245A.66, subdivision 3, is amended to read:

Subd. 3. ~~**Orientation to**~~ **Yearly review of risk reduction plan** ~~**and annual review of plan.** (a) The license holder shall ensure that all mandated reporters, as defined in section 626.556, subdivision 3, who are under the control of the license holder, receive an orientation to the risk reduction plan prior to first providing unsupervised direct contact services, as defined in section 245C.02, subdivision 11, to children, not to exceed 14 days from the first supervised direct contact, and annually thereafter. The license holder must document the orientation to the risk reduction plan in the mandated reporter's personnel records.~~

~~(b)~~ The license holder must review the risk reduction plan ~~annually~~ each calendar year and document the ~~annual~~ review. When conducting the review, the license holder must consider incidents that have occurred in the center since the last review, including:

(1) the assessment factors in the plan;

(2) the internal reviews conducted under this section, if any;

(3) substantiated maltreatment findings, if any; and

(4) incidents that caused injury or harm to a child, if any, that occurred since the last review.

Following any change to the risk reduction plan, the license holder must inform ~~mandated reporters~~ staff persons, under the control of the license holder, of the changes in the risk reduction plan, and document that the ~~mandated reporters~~ staff were informed of the changes.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 19. Minnesota Statutes 2018, section 245C.02, is amended by adding a subdivision to read:

Subd. 5a. **License-exempt child care center certification holder.** "License-exempt child care center certification holder" has the meaning given for "certification holder" in section 245H.01, subdivision 4.

Sec. 20. Minnesota Statutes 2018, section 245C.02, subdivision 6a, is amended to read:

Subd. 6a. **Child care background study subject.** (a) "Child care background study subject" means an individual who is affiliated with a licensed child care center, certified

license exempt child care center, licensed family child care program, or legal nonlicensed child care provider authorized under chapter 119B, and who is:

(1) ~~who is~~ employed by a child care provider for compensation;

(2) ~~whose activities involve~~ assisting in the ~~supervision~~ care of a child for a child care provider; ~~or~~

~~(3) who is required to have a background study under section 245C.03, subdivision 1.~~

(3) a person applying for licensure, certification, or enrollment;

(4) a controlling individual as defined in section 245A.02, subdivision 5a;

(5) an individual 13 years of age or older who lives in the household where the licensed program will be provided and who is not receiving licensed services from the program;

(6) an individual ten to 12 years of age who lives in the household where the licensed services will be provided when the commissioner has reasonable cause as defined in section 245C.02, subdivision 15;

(7) an individual who, without providing direct contact services at a licensed program, certified program, or program authorized under chapter 119B, may have unsupervised access to a child receiving services from a program when the commissioner has reasonable cause as defined in section 245C.02, subdivision 15; or

(8) a volunteer, contractor, prospective employee, or other individual who has unsupervised physical access to a child served by a program and who is not under direct, continuous supervision by an individual listed in clause (1) or (5), regardless of whether the individual provides program services.

(b) Notwithstanding paragraph (a), an individual who is providing services that are not part of the child care program is not required to have a background study if:

(1) the child receiving services is signed out of the child care program for the duration that the services are provided;

(2) the licensed program, certified program, or program authorized under chapter 119B has obtained advanced written permission from the parent authorizing the child to receive the services, which is maintained in the child's record;

(3) the license holder maintains documentation on-site that identifies the individual service provider and the services being provided; and

(4) the license holder ensures that the service provider does not have unsupervised access to a child not receiving the provider's services.

Sec. 21. Minnesota Statutes 2018, section 245C.03, subdivision 1, is amended to read:

Subdivision 1. **Licensed programs.** (a) The commissioner shall conduct a background study on:

(1) the person or persons applying for a license;

(2) an individual age 13 and over living in the household where the licensed program will be provided who is not receiving licensed services from the program;

(3) current or prospective employees or contractors of the applicant who will have direct contact with persons served by the facility, agency, or program;

(4) volunteers or student volunteers who will have direct contact with persons served by the program to provide program services if the contact is not under the continuous, direct supervision by an individual listed in clause (1) or (3);

(5) an individual age ten to 12 living in the household where the licensed services will be provided when the commissioner has reasonable cause as defined in section 245C.02, subdivision 15;

(6) an individual who, without providing direct contact services at a licensed program, may have unsupervised access to children or vulnerable adults receiving services from a program, when the commissioner has reasonable cause as defined in section 245C.02, subdivision 15;

(7) all controlling individuals as defined in section 245A.02, subdivision 5a; and

(8) notwithstanding the other requirements in this subdivision, child care background study subjects as defined in section 245C.02, subdivision 6a.

~~(b) Paragraph (a), clauses (2), (5), and (6), apply to legal nonlicensed child care and certified license-exempt child care programs.~~

~~(c)~~ (b) For child foster care when the license holder resides in the home where foster care services are provided, a short-term substitute caregiver providing direct contact services for a child for less than 72 hours of continuous care is not required to receive a background study under this chapter.

Sec. 22. Minnesota Statutes 2018, section 245C.05, subdivision 5a, is amended to read:

Subd. 5a. **Background study requirements for minors.** (a) A background study completed under this chapter on a subject who is required to be studied under section 245C.03, subdivision 1, and is 17 years of age or younger shall be completed by the commissioner for:

(1) a legal nonlicensed child care provider authorized under chapter 119B;

(2) a licensed family child care program; or

(3) a licensed foster care home.

(b) The subject shall submit to the commissioner only the information under subdivision 1, paragraph (a).

(c) A subject who is 17 years of age or younger is required to submit fingerprints and a photograph, and the commissioner shall conduct a national criminal history record check, if:

(1) the commissioner has reasonable cause to require a national criminal history record check defined in section 245C.02, subdivision 15a; or

(2) under paragraph (a), clauses (1) and (2), the subject is employed by the provider or supervises children served by the program.

(d) A subject who is 17 years of age or younger is required to submit non-fingerprint-based data according to section 245C.08, subdivision 1, paragraph (a), clause (6), item (iii), and the commissioner shall conduct the check if:

(1) the commissioner has reasonable cause to require a national criminal history record check defined in section 245C.02, subdivision 15a; or

(2) the subject is employed by the provider or supervises children served by the program under paragraph (a), clauses (1) and (2).

Sec. 23. Minnesota Statutes 2018, section 245C.08, subdivision 1, is amended to read:

Subdivision 1. **Background studies conducted by Department of Human Services.** (a) For a background study conducted by the Department of Human Services, the commissioner shall review:

(1) information related to names of substantiated perpetrators of maltreatment of vulnerable adults that has been received by the commissioner as required under section 626.557, subdivision 9c, paragraph (j);

(2) the commissioner's records relating to the maltreatment of minors in licensed programs, and from findings of maltreatment of minors as indicated through the social service information system;

(3) information from juvenile courts as required in subdivision 4 for individuals listed in section 245C.03, subdivision 1, paragraph (a), when there is reasonable cause;

(4) information from the Bureau of Criminal Apprehension, including information regarding a background study subject's registration in Minnesota as a predatory offender under section 243.166;

(5) except as provided in clause (6), information received as a result of submission of fingerprints for a national criminal history record check, as defined in section 245C.02, subdivision 13c, when the commissioner has reasonable cause for a national criminal history record check as defined under section 245C.02, subdivision 15a, or as required under section 144.057, subdivision 1, clause (2);

(6) for a background study related to a child foster care application for licensure, a transfer of permanent legal and physical custody of a child under sections 260C.503 to 260C.515, or adoptions, and for a background study required for family child care, certified license-exempt child care, child care centers, and legal nonlicensed child care authorized under chapter 119B, the commissioner shall also review:

(i) information from the child abuse and neglect registry for any state in which the background study subject has resided for the past five years; ~~and~~

(ii) when the background study subject is 18 years of age or older, or a minor under section 245C.05, subdivision 5a, paragraph (c), information received following submission of fingerprints for a national criminal history record check; and

(iii) when the background study subject is 18 years of age or older or a minor under section 245C.05, subdivision 5a, paragraph (d), for licensed family child care, certified license-exempt child care, licensed child care centers, and legal nonlicensed child care authorized under chapter 119B, information obtained using non-fingerprint-based data including information from the criminal and sex offender registries for any state in which the background study subject resided for the past five years and information from the national crime information database and the national sex offender registry; and

(7) for a background study required for family child care, certified license-exempt child care centers, licensed child care centers, and legal nonlicensed child care authorized under

chapter 119B, the background study shall also include, to the extent practicable, a name and date-of-birth search of the National Sex Offender Public website.

(b) Notwithstanding expungement by a court, the commissioner may consider information obtained under paragraph (a), clauses (3) and (4), unless the commissioner received notice of the petition for expungement and the court order for expungement is directed specifically to the commissioner.

(c) The commissioner shall also review criminal case information received according to section 245C.04, subdivision 4a, from the Minnesota court information system that relates to individuals who have already been studied under this chapter and who remain affiliated with the agency that initiated the background study.

(d) When the commissioner has reasonable cause to believe that the identity of a background study subject is uncertain, the commissioner may require the subject to provide a set of classifiable fingerprints for purposes of completing a fingerprint-based record check with the Bureau of Criminal Apprehension. Fingerprints collected under this paragraph shall not be saved by the commissioner after they have been used to verify the identity of the background study subject against the particular criminal record in question.

(e) The commissioner may inform the entity that initiated a background study under NETStudy 2.0 of the status of processing of the subject's fingerprints.

Sec. 24. Minnesota Statutes 2018, section 245C.08, subdivision 3, is amended to read:

Subd. 3. **Arrest and investigative information.** (a) For any background study completed under this section, if the commissioner has reasonable cause to believe the information is pertinent to the disqualification of an individual, the commissioner also may review arrest and investigative information from:

(1) the Bureau of Criminal Apprehension;

(2) the ~~commissioner~~ commissioners of health and human services;

(3) a county attorney;

(4) a county sheriff;

(5) a county agency;

(6) a local chief of police;

(7) other states;

(8) the courts;

(9) the Federal Bureau of Investigation;

(10) the National Criminal Records Repository; and

(11) criminal records from other states.

(b) Except as required by law, the commissioner is not required to conduct more than one review of a subject's records from the Federal Bureau of Investigation if a review of the subject's criminal history with the Federal Bureau of Investigation has already been completed by the commissioner and there has been no break in the subject's affiliation with the ~~license holder who~~ entity that initiated the background study.

(c) If the commissioner conducts a national criminal history record check when required by law and uses the relevant information under paragraph (a), clauses (9) and (10), to make a disqualification determination: (1) the data is private and cannot be shared with county agencies, private agencies, or prospective employers of the study subject; and (2) the license holder or other entity that submitted the study is not required to obtain a copy of the study subject's notice of disqualification under section 245C.17, subdivision 3.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 25. Minnesota Statutes 2018, section 245C.30, subdivision 1, is amended to read:

Subdivision 1. **License holder and license-exempt child care center certification holder variance.** (a) Except for any disqualification under section 245C.15, subdivision 1, when the commissioner has not set aside a background study subject's disqualification, and there are conditions under which the disqualified individual may provide direct contact services or have access to people receiving services that minimize the risk of harm to people receiving services, the commissioner may grant a time-limited variance to a license holder or license-exempt child care center certification holder.

(b) The variance shall state the reason for the disqualification, the services that may be provided by the disqualified individual, and the conditions with which the license holder, license-exempt child care center certification holder, or applicant must comply for the variance to remain in effect.

(c) Except for programs licensed to provide family child care, foster care for children in the provider's own home, or foster care or day care services for adults in the provider's own home, the variance must be requested by the license holder or license-exempt child care center certification holder.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 26. Minnesota Statutes 2018, section 245C.30, subdivision 2, is amended to read:

Subd. 2. **Disclosure of reason for disqualification.** (a) The commissioner may not grant a variance for a disqualified individual unless the applicant, license-exempt child care center certification holder, or license holder requests the variance and the disqualified individual provides written consent for the commissioner to disclose to the applicant, license-exempt child care center certification holder, or license holder the reason for the disqualification.

(b) This subdivision does not apply to programs licensed to provide family child care for children, foster care for children in the provider's own home, or foster care or day care services for adults in the provider's own home. When the commissioner grants a variance for a disqualified individual in connection with a license to provide the services specified in this paragraph, the disqualified individual's consent is not required to disclose the reason for the disqualification to the license holder in the variance issued under subdivision 1, provided that the commissioner may not disclose the reason for the disqualification if the disqualification is based on a felony-level conviction for a drug-related offense within the past five years.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 27. Minnesota Statutes 2018, section 245C.30, subdivision 3, is amended to read:

Subd. 3. **Consequences for failing to comply with conditions of variance.** When a license holder or license-exempt child care center certification holder permits a disqualified individual to provide any services for which the subject is disqualified without complying with the conditions of the variance, the commissioner may terminate the variance effective immediately and subject the license holder to a licensing action under sections 245A.06 and 245A.07 or a license-exempt child care center certification holder to an action under sections 245H.06 and 245H.07.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 28. Minnesota Statutes 2018, section 245H.01, is amended by adding a subdivision to read:

Subd. 7. **Substitute.** "Substitute" means an adult who is temporarily filling a position as a staff person for less than 240 hours total in a calendar year due to the absence of a regularly employed staff person who provides direct contact services to a child.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 29. Minnesota Statutes 2018, section 245H.01, is amended by adding a subdivision to read:

Subd. 8. **Staff person.** "Staff person" means an employee of a certified center who provides direct contact services to children.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 30. Minnesota Statutes 2018, section 245H.01, is amended by adding a subdivision to read:

Subd. 9. **Unsupervised volunteer.** "Unsupervised volunteer" means an individual who: (1) assists in the care of a child in care; (2) is not under the continuous direct supervision of a staff person; and (3) is not employed by the certified center.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 31. Minnesota Statutes 2018, section 245H.03, is amended by adding a subdivision to read:

Subd. 4. **Reconsideration of certification denial.** (a) The applicant may request reconsideration of the denial by notifying the commissioner by certified mail or personal service. The request must be made in writing. If sent by certified mail, the request must be postmarked and sent to the commissioner within ten calendar days after the applicant received the order. If a request is made by personal service, it must be received by the commissioner within ten calendar days after the applicant received the order. The applicant may submit with the request for reconsideration a written argument or evidence in support of the request for reconsideration.

(b) The commissioner's disposition of a request for reconsideration is final and not subject to appeal under chapter 14.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 32. Minnesota Statutes 2018, section 245H.07, is amended to read:

245H.07 DECERTIFICATION.

Subdivision 1. **Generally.** (a) The commissioner may decertify a center if a certification holder:

(1) failed to comply with an applicable law or rule; or

(2) knowingly withheld relevant information from or gave false or misleading information to the commissioner in connection with an application for certification, in connection with the background study status of an individual, during an investigation, or regarding compliance with applicable laws or rules.

(b) When considering decertification, the commissioner shall consider the nature, chronicity, or severity of the violation of law or rule.

(c) When a center is decertified, the center is ineligible to receive a child care assistance payment.

Subd. 2. **Reconsideration of decertification.** (a) The certification holder may request reconsideration of the decertification by notifying the commissioner by certified mail or personal service. The request must be made in writing. If sent by certified mail, the request must be postmarked and sent to the commissioner within ten calendar days after the certification holder received the order. If a request is made by personal service, it must be received by the commissioner within ten calendar days after the certification holder received the order. With the request for reconsideration, the certification holder may submit a written argument or evidence in support of the request for reconsideration.

(b) If the commissioner decertifies a center pursuant to subdivision 1, paragraph (a), clause (1), based on a determination that the center was responsible for maltreatment, and if the center requests reconsideration of the decertification according to this subdivision and appeals the maltreatment determination under section 626.556, subdivision 10i, the final decertification determination is stayed until the commissioner issues a final decision regarding the maltreatment appeal.

(c) The commissioner's disposition of a request for reconsideration is final and not subject to appeal under chapter 14.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 33. Minnesota Statutes 2018, section 245H.10, subdivision 1, is amended to read:

Subdivision 1. **Documentation.** (a) The applicant or certification holder must submit and maintain documentation of a completed background study for:

(1) each person applying for the certification;

(2) each person identified as a center operator or program operator as defined in section 245H.01, subdivision 3;

(3) each current or prospective staff person or contractor of the certified center who will have direct contact with a child served by the center;

(4) each volunteer who has direct contact with a child served by the center if the contact is not under the continuous, direct supervision by an individual listed in clause (1), (2), or (3); and

(5) each managerial staff person of the certification holder with oversight and supervision of the certified center.

(b) To be accepted for certification, a background study on every individual in paragraph (a), clause (1), must be completed under chapter 245C and result in a not disqualified determination under section 245C.14 or a disqualification that was set aside under section 245C.22 or was issued a variance under section 245C.30.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 34. Minnesota Statutes 2018, section 245H.11, is amended to read:

245H.11 REPORTING.

(a) The certification holder must comply and must have written policies for staff to comply with the reporting requirements for abuse and neglect specified in section 626.556. A person mandated to report physical or sexual child abuse or neglect occurring within a certified center shall report the information to the commissioner.

(b) The certification holder must inform the commissioner within 24 hours of:

(1) the death of a child in the program; and

(2) any injury to a child in the program that required treatment by a physician.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 35. Minnesota Statutes 2018, section 245H.12, is amended to read:

245H.12 FEES.

~~The commissioner shall consult with stakeholders to develop an administrative fee to implement this chapter. By February 15, 2019, the commissioner shall provide recommendations on the amount of an administrative fee to the legislative committees with jurisdiction over health and human services policy and finance.~~ A certified center must pay an initial application fee of $200 and an annual nonrefundable renewal fee of $100.

EFFECTIVE DATE. This section is effective for any center that applies for certification or certified center that renews the center's certification to provide services on January 1, 2020, and thereafter.

Sec. 36. Minnesota Statutes 2018, section 245H.13, subdivision 5, is amended to read:

Subd. 5. **Building and physical premises; free of hazards.** (a) ~~The certified center must document compliance with the State Fire Code by providing~~ To be accepted for certification, the applicant must demonstrate compliance with the State Fire Code, section 299F.011, by either:

(1) providing documentation of a fire marshal inspection completed within the previous three years by a state fire marshal or a local fire code inspector trained by the state fire marshal~~.~~; or

(2) complying with the fire marshal inspection requirements according to section 245A.151.

(b) The certified center must designate a primary indoor and outdoor space used for child care on a facility site floor plan.

(c) The certified center must ensure the areas used by a child are clean and in good repair, with structurally sound and functional furniture and equipment that is appropriate to the age and size of a child who uses the area.

(d) The certified center must ensure hazardous items including but not limited to sharp objects, medicines, cleaning supplies, poisonous plants, and chemicals are out of reach of a child.

(e) The certified center must safely handle and dispose of bodily fluids and other potentially infectious fluids by using gloves, disinfecting surfaces that come in contact with potentially infectious bodily fluids, and disposing of bodily fluid in a securely sealed plastic bag.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 37. Minnesota Statutes 2018, section 245H.13, is amended by adding a subdivision to read:

Subd. 7. **Risk reduction plan.** (a) The certified center must develop a risk reduction plan that identifies risks to children served by the child care center. The assessment of risk must include risks presented by (1) the physical plant where the certified services are

provided, including electrical hazards; and (2) the environment, including the proximity to busy roads and bodies of water.

(b) The certification holder must establish policies and procedures to minimize identified risks. After any change to the risk reduction plan, the certification holder must inform staff of the change in the risk reduction plan and document that staff were informed of the change.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 38. Minnesota Statutes 2018, section 245H.13, is amended by adding a subdivision to read:

Subd. 8. **Required policies.** A certified center must have written policies for health and safety items in subdivisions 1 to 6.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 39. Minnesota Statutes 2018, section 245H.13, is amended by adding a subdivision to read:

Subd. 9. **Behavior guidance.** The certified center must ensure that staff and volunteers use positive behavior guidance and do not subject children to:

(1) corporal punishment, including but not limited to rough handling, shoving, hair pulling, ear pulling, shaking, slapping, kicking, biting, pinching, hitting, and spanking;

(2) humiliation;

(3) abusive language;

(4) the use of mechanical restraints, including tying;

(5) the use of physical restraints other than to physically hold a child when containment is necessary to protect a child or others from harm; or

(6) the withholding or forcing of food and other basic needs.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 40. Minnesota Statutes 2018, section 245H.13, is amended by adding a subdivision to read:

Subd. 10. **Supervision.** Staff must supervise each child at all times. Staff are responsible for the ongoing activity of each child, appropriate visual or auditory awareness, physical proximity, and knowledge of activity requirements and each child's needs. Staff must

intervene when necessary to ensure a child's safety. In determining the appropriate level of supervision of a child, staff must consider: (1) the age of a child; (2) individual differences and abilities; (3) indoor and outdoor layout of the child care program; and (4) environmental circumstances, hazards, and risks.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 41. Minnesota Statutes 2018, section 245H.14, subdivision 1, is amended to read:

Subdivision 1. **First aid and cardiopulmonary resuscitation.** ~~At least one designated staff person who completed pediatric first aid training and pediatric cardiopulmonary resuscitation (CPR) training must be present at all times at the program, during field trips, and when transporting a child. The designated staff person must repeat pediatric first aid training and pediatric CPR training at least once every two years.~~

(a) Before having unsupervised direct contact with a child, but within the first 90 days of employment, the director and all staff persons, including substitutes and unsupervised volunteers who have direct contact with a child, must successfully complete pediatric first aid and pediatric cardiopulmonary resuscitation (CPR) training, unless the training has been completed within the previous two calendar years. Staff must complete the pediatric first aid and pediatric CPR training at least every other calendar year and the center must document the training in the staff person's personnel record.

(b) Training completed under this subdivision may be used to meet the in-service training requirements under subdivision 6.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 42. Minnesota Statutes 2018, section 245H.14, subdivision 3, is amended to read:

Subd. 3. **Abusive head trauma.** A certified center that cares for a child ~~through four years of age~~ under school age must ensure that the director and all staff persons ~~and volunteers~~, including substitutes and unsupervised volunteers, receive training on abusive head trauma ~~from shaking infants and young children~~ before assisting in the care of a child ~~through four years of age~~ under school age.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 43. Minnesota Statutes 2018, section 245H.14, subdivision 4, is amended to read:

Subd. 4. **Child development.** The certified center must ensure ~~each staff person completes at least two hours of~~ that the director and all staff persons, including substitutes and

unsupervised volunteers, complete child development and learning training within ~~14~~ 90 days of employment and ~~annually~~ every second calendar year thereafter. The director and staff persons not including substitutes must complete at least two hours of training on child development. The training for substitutes and unsupervised volunteers is not required to be of a minimum length. For purposes of this subdivision, "child development and learning training" means how a child develops physically, cognitively, emotionally, and socially and learns as part of the child's family, culture, and community.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 44. Minnesota Statutes 2018, section 245H.14, subdivision 5, is amended to read:

Subd. 5. **Orientation.** The certified center must ensure ~~each staff person is~~ the director and all staff persons, substitutes, and unsupervised volunteers are trained at orientation on health and safety requirements in sections 245H.11, 245H.13, 245H.14, and 245H.15. The certified center must provide ~~staff with an~~ the orientation within 14 days of employment or first date of direct contact with a child, whichever is earlier. Before the completion of orientation, ~~a staff person~~ these individuals must be supervised while providing direct care to a child.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 45. Minnesota Statutes 2018, section 245H.14, subdivision 6, is amended to read:

Subd. 6. **In service.** (a) The certified center must ensure ~~each~~ that the director and all staff ~~person is~~ persons, including substitutes and unsupervised volunteers, are trained at least ~~annually~~ once each calendar year on health and safety requirements in sections 245H.11, 245H.13, 245H.14, and 245H.15.

(b) The director and each staff person, not including substitutes, must ~~annually~~ complete at least six hours of training each calendar year. Training required under paragraph (a) may be used toward the hourly training requirements of this subdivision.

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 46. Minnesota Statutes 2018, section 245H.15, subdivision 1, is amended to read:

Subdivision 1. **Written emergency plan.** (a) A certified center must have a written emergency plan for emergencies that require evacuation, sheltering, or other protection of children, such as fire, natural disaster, intruder, or other threatening situation that may pose a health or safety hazard to children. The plan must be written on a form developed by the

commissioner and reviewed and updated at least once each calendar year. The annual review of the emergency plan must be documented.

(b) The plan must include:

(1) procedures for an evacuation, relocation, shelter-in-place, or lockdown;

(2) a designated relocation site and evacuation route;

(3) procedures for notifying a child's parent or legal guardian of the relocation and reunification with families;

(4) accommodations for a child with a disability or a chronic medical condition;

(5) procedures for storing a child's medically necessary medicine that facilitates easy removal during an evacuation or relocation;

(6) procedures for continuing operations in the period during and after a crisis; ~~and~~

(7) procedures for communicating with local emergency management officials, law enforcement officials, or other appropriate state or local authorities; and

(8) accommodations for infants and toddlers.

~~(c) The certification holder must have an emergency plan available for review upon request by the child's parent or legal guardian.~~

EFFECTIVE DATE. This section is effective September 30, 2019.

Sec. 47. **REPEALER.**

Minnesota Rules, parts 9502.0425, subparts 4, 16, and 17; and 9503.0155, subpart 8, are repealed.

EFFECTIVE DATE. This section is effective September 30, 2019.

ARTICLE 3
DIRECT CARE AND TREATMENT

Section 1. Minnesota Statutes 2018, section 246B.10, is amended to read:

246B.10 LIABILITY OF COUNTY; REIMBURSEMENT.

(a) The civilly committed sex offender's county shall pay to the state a portion of the cost of care provided in the Minnesota sex offender program to a civilly committed sex offender who has legally settled in that county.

(b) A county's payment must be made from the county's own sources of revenue and payments must:

(1) equal ten percent of the cost of care, as determined by the commissioner, for each day or portion of a day that the civilly committed sex offender spends at the facility for individuals admitted to the Minnesota sex offender program before August 1, 2011; or

(2) equal 25 percent of the cost of care, as determined by the commissioner, for each day or portion of a day~~,~~ that the civilly committed sex offender:

(i) spends at the facility~~.~~ for individuals admitted to the Minnesota sex offender program on or after August 1, 2011; or

(ii) receives services within a program operated by the Minnesota sex offender program while on provisional discharge.

(c) The county is responsible for paying the state the remaining amount if payments received by the state under this chapter exceed:

(1) 90 percent of the cost of care for individuals admitted to the Minnesota sex offender program before August 1, 2011; or

(2) 75 percent of the cost of care~~, the county is responsible for paying the state the remaining amount~~ for individuals:

(i) admitted to the Minnesota sex offender program on or after August 1, 2011; or

(ii) receiving services within a program operated by the Minnesota sex offender program while on provisional discharge.

(d) The county is not entitled to reimbursement from the civilly committed sex offender, the civilly committed sex offender's estate, or from the civilly committed sex offender's relatives, except as provided in section 246B.07.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 2. **REPEALER.**

(a) Minnesota Statutes 2018, section 246.18, subdivisions 8 and 9, are repealed.

(b) Laws 2010, First Special Session chapter 1, article 25, section 3, subdivision 10, is repealed.

ARTICLE 4
CONTINUING CARE FOR OLDER ADULTS

Section 1. Minnesota Statutes 2018, section 144.0724, subdivision 4, is amended to read:

Subd. 4. **Resident assessment schedule.** (a) A facility must conduct and electronically submit to the commissioner of health MDS assessments that conform with the assessment schedule defined by Code of Federal Regulations, title 42, section 483.20, and published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, in the Long Term Care Assessment Instrument User's Manual, version 3.0, and subsequent updates when issued by the Centers for Medicare and Medicaid Services. The commissioner of health may substitute successor manuals or question and answer documents published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, to replace or supplement the current version of the manual or document.

(b) The assessments used to determine a case mix classification for reimbursement include the following:

(1) a new admission assessment;

(2) an annual assessment which must have an assessment reference date (ARD) within 92 days of the previous assessment and the previous comprehensive assessment;

(3) a significant change in status assessment must be completed within 14 days of the identification of a significant change, whether improvement or decline, and regardless of the amount of time since the last significant change in status assessment~~;~~. Effective for rehabilitation therapy completed on or after January 1, 2020, a facility must complete a significant change in status assessment if for any reason all speech, occupational, and physical therapies have ended. The ARD of the significant change in status assessment must be the eighth day after all speech, occupational, and physical therapies have ended. The last day on which rehabilitation therapy was furnished is considered day zero when determining the ARD for the significant change in status assessment;

(4) all quarterly assessments must have an assessment reference date (ARD) within 92 days of the ARD of the previous assessment;

(5) any significant correction to a prior comprehensive assessment, if the assessment being corrected is the current one being used for RUG classification; ~~and~~

(6) any significant correction to a prior quarterly assessment, if the assessment being corrected is the current one being used for RUG classification~~.~~; and

(7) modifications to the most recent assessment in clauses (1) to (6).

(c) In addition to the assessments listed in paragraph (b), the assessments used to determine nursing facility level of care include the following:

(1) preadmission screening completed under section 256.975, subdivisions 7a to 7c, by the Senior LinkAge Line or other organization under contract with the Minnesota Board on Aging; and

(2) a nursing facility level of care determination as provided for under section 256B.0911, subdivision 4e, as part of a face-to-face long-term care consultation assessment completed under section 256B.0911, by a county, tribe, or managed care organization under contract with the Department of Human Services.

Sec. 2. Minnesota Statutes 2018, section 144.0724, subdivision 5, is amended to read:

Subd. 5. **Short stays.** (a) A facility must submit to the commissioner of health an admission assessment for all residents who stay in the facility 14 days or less.

(b) Notwithstanding the admission assessment requirements of paragraph (a), a facility may elect to accept a short stay rate with a case mix index of 1.0 for all facility residents who stay 14 days or less in lieu of submitting an admission assessment. Facilities shall make this election annually.

(c) Nursing facilities must elect one of the options described in paragraphs (a) and (b) by reporting to the commissioner of health, as prescribed by the commissioner. The election is effective on July 1 each year.

(d) An admission assessment is not required regardless of the facility's election status when a resident is admitted to and discharged from the facility on the same day.

EFFECTIVE DATE. This section is effective for admissions on or after July 1, 2019.

Sec. 3. Minnesota Statutes 2018, section 144.0724, subdivision 8, is amended to read:

Subd. 8. **Request for reconsideration of resident classifications.** (a) The resident, or resident's representative, or the nursing facility or boarding care home may request that the commissioner of health reconsider the assigned reimbursement classification including any items changed during the audit process. The request for reconsideration must be submitted in writing to the commissioner within 30 days of the day the resident or the resident's representative receives the resident classification notice. The request for reconsideration must include the name of the resident, the name and address of the facility in which the

resident resides, the reasons for the reconsideration, and documentation supporting the request. The documentation accompanying the reconsideration request is limited to ~~a copy of the MDS that determined the classification and other~~ documents that would support or change the MDS findings.

(b) Upon request, the nursing facility must give the resident or the resident's representative a copy of the assessment form and the other documentation that was given to the commissioner of health to support the assessment findings. The nursing facility shall also provide access to and a copy of other information from the resident's record that has been requested by or on behalf of the resident to support a resident's reconsideration request. A copy of any requested material must be provided within three working days of receipt of a written request for the information. Notwithstanding any law to the contrary, the facility may not charge a fee for providing copies of the requested documentation. If a facility fails to provide the material within this time, it is subject to the issuance of a correction order and penalty assessment under sections 144.653 and 144A.10. Notwithstanding those sections, any correction order issued under this subdivision must require that the nursing facility immediately comply with the request for information and that as of the date of the issuance of the correction order, the facility shall forfeit to the state a $100 fine for the first day of noncompliance, and an increase in the $100 fine by $50 increments for each day the noncompliance continues.

(c) In addition to the information required under paragraphs (a) and (b), a reconsideration request from a nursing facility must contain the following information: (i) the date the reimbursement classification notices were received by the facility; (ii) the date the classification notices were distributed to the resident or the resident's representative; and (iii) a copy of a notice sent to the resident or to the resident's representative. This notice must inform the resident or the resident's representative that a reconsideration of the resident's classification is being requested, the reason for the request, that the resident's rate will change if the request is approved by the commissioner, the extent of the change, that copies of the facility's request and supporting documentation are available for review, and that the resident also has the right to request a reconsideration. If the facility fails to provide the required information listed in item (iii) with the reconsideration request, the commissioner may request that the facility provide the information within 14 calendar days. The reconsideration request must be denied if the information is then not provided, and the facility may not make further reconsideration requests on that specific reimbursement classification.

(d) Reconsideration by the commissioner must be made by individuals not involved in reviewing the assessment, audit, or reconsideration that established the disputed classification.

The reconsideration must be based upon the assessment that determined the classification and upon the information provided to the commissioner under paragraphs (a) and (b). If necessary for evaluating the reconsideration request, the commissioner may conduct on-site reviews. Within 15 working days of receiving the request for reconsideration, the commissioner shall affirm or modify the original resident classification. The original classification must be modified if the commissioner determines that the assessment resulting in the classification did not accurately reflect characteristics of the resident at the time of the assessment. The resident and the nursing facility or boarding care home shall be notified within five working days after the decision is made. A decision by the commissioner under this subdivision is the final administrative decision of the agency for the party requesting reconsideration.

(e) The resident classification established by the commissioner shall be the classification that applies to the resident while the request for reconsideration is pending. If a request for reconsideration applies to an assessment used to determine nursing facility level of care under subdivision 4, paragraph (c), the resident shall continue to be eligible for nursing facility level of care while the request for reconsideration is pending.

(f) The commissioner may request additional documentation regarding a reconsideration necessary to make an accurate reconsideration determination.

Sec. 4. Minnesota Statutes 2018, section 144A.071, subdivision 1a, is amended to read:

Subd. 1a. **Definitions.** For purposes of sections 144A.071 to 144A.073, the following terms have the meanings given them:

(a) "Attached fixtures" has the meaning given in Minnesota Rules, part 9549.0020, subpart 6.

(b) ~~"Buildings"~~ "Building" has the meaning given in ~~Minnesota Rules, part 9549.0020, subpart 7~~ section 256R.261, subdivision 4.

(c) "Capital assets" has the meaning given in section ~~256B.421, subdivision 16~~ 256R.02, subdivision 8.

(d) "Commenced construction" means that all of the following conditions were met: the final working drawings and specifications were approved by the commissioner of health; the construction contracts were let; a timely construction schedule was developed, stipulating dates for beginning, achieving various stages, and completing construction; and all zoning and building permits were applied for.

(e) "Completion date" means the date on which clearance for the construction project is issued, or if a clearance for the construction project is not required, the date on which the construction project assets are available for facility use.

(f) "Construction" means any erection, building, alteration, reconstruction, modernization, or improvement necessary to comply with the nursing home licensure rules.

(g) "Construction project" means:

(1) a capital asset addition to, or replacement of a nursing home or certified boarding care home that results in new space or the remodeling of or renovations to existing facility space; and

(2) the remodeling or renovation of existing facility space the use of which is modified as a result of the project described in clause (1). This existing space and the project described in clause (1) must be used for the functions as designated on the construction plans on completion of the project described in clause (1) for a period of not less than 24 months.

(h) "Depreciation guidelines" ~~means the most recent publication of "The Estimated Useful Lives of Depreciable Hospital Assets," issued by the American Hospital Association, 840 North Lake Shore Drive, Chicago, Illinois, 60611~~ has the meaning given in section 256R.261, subdivision 9.

(i) "New licensed" or "new certified beds" means:

(1) newly constructed beds in a facility or the construction of a new facility that would increase the total number of licensed nursing home beds or certified boarding care or nursing home beds in the state; or

(2) newly licensed nursing home beds or newly certified boarding care or nursing home beds that result from remodeling of the facility that involves relocation of beds but does not result in an increase in the total number of beds, except when the project involves the upgrade of boarding care beds to nursing home beds, as defined in section 144A.073, subdivision 1. "Remodeling" includes any of the type of conversion, renovation, replacement, or upgrading projects as defined in section 144A.073, subdivision 1.

~~(j) "Project construction costs" means the cost of the following items that have a completion date within 12 months before or after the completion date of the project described in item (g), clause (1):~~

~~(1) facility capital asset additions;~~

~~(2) replacements;~~

~~(3) renovations;~~

~~(4) remodeling projects;~~

~~(5) construction site preparation costs;~~

~~(6) related soft costs; and~~

~~(7) the cost of new technology implemented as part of the construction project and depreciable equipment directly identified to the project, if the construction costs for clauses (1) to (6) exceed the threshold for additions and replacements stated in section 256B.431, subdivision 16. Technology and depreciable equipment shall be included in the project construction costs unless a written election is made by the facility, to not include it in the facility's appraised value for purposes of Minnesota Rules, part 9549.0020, subpart 5. Debt incurred for purchase of technology and depreciable equipment shall be included as allowable debt for purposes of Minnesota Rules, part 9549.0060, subpart 5, items A and C, unless the written election is to not include it. Any new technology and depreciable equipment included in the project construction costs that the facility elects not to include in its appraised value and allowable debt shall be treated as provided in section 256B.431, subdivision 17, paragraph (b). Written election under this paragraph must be included in the facility's request for the rate change related to the project, and this election may not be changed.~~

~~(k) "Technology" means information systems or devices that make documentation, charting, and staff time more efficient or encourage and allow for care through alternative settings including, but not limited to, touch screens, monitors, hand-helds, swipe cards, motion detectors, pagers, telemedicine, medication dispensers, and equipment to monitor vital signs and self-injections, and to observe skin and other conditions.~~

EFFECTIVE DATE. This section is effective January 1, 2020.

Sec. 5. Minnesota Statutes 2018, section 144A.071, subdivision 2, is amended to read:

Subd. 2. **Moratorium.** The commissioner of health, in coordination with the commissioner of human services, shall deny each request for new licensed or certified nursing home or certified boarding care beds except as provided in subdivision 3 or 4a, or section 144A.073. "Certified bed" means a nursing home bed or a boarding care bed certified by the commissioner of health for the purposes of the medical assistance program, under United States Code, title 42, sections 1396 et seq. Certified beds in facilities which do not allow medical assistance intake shall be deemed to be decertified for purposes of this section only.

The commissioner of human services, in coordination with the commissioner of health, shall deny any request to issue a license under section 252.28 and chapter 245A to a nursing home or boarding care home, if that license would result in an increase in the medical assistance reimbursement amount.

In addition, the commissioner of health must not approve any construction project whose cost exceeds ~~$1,000,000~~ $1,500,000, unless:

(a) any construction costs exceeding ~~$1,000,000~~ $1,500,000 are not added to the facility's appraised value and are not included in the facility's payment rate for reimbursement under the medical assistance program; or

(b) the project:

(1) has been approved through the process described in section 144A.073;

(2) meets an exception in subdivision 3 or 4a;

(3) is necessary to correct violations of state or federal law issued by the commissioner of health;

(4) is necessary to repair or replace a portion of the facility that was damaged by fire, lightning, ground shifts, or other such hazards, including environmental hazards, provided that the provisions of subdivision 4a, clause (a), are met;

(5) as of May 1, 1992, the facility has submitted to the commissioner of health written documentation evidencing that the facility meets the "commenced construction" definition as specified in subdivision 1a, paragraph (d), or that substantial steps have been taken prior to April 1, 1992, relating to the construction project. "Substantial steps" require that the facility has made arrangements with outside parties relating to the construction project and include the hiring of an architect or construction firm, submission of preliminary plans to the Department of Health or documentation from a financial institution that financing arrangements for the construction project have been made; or

(6) is being proposed by a licensed nursing facility that is not certified to participate in the medical assistance program and will not result in new licensed or certified beds.

Prior to the final plan approval of any construction project, the ~~commissioner~~ commissioners of health and human services shall be provided with an itemized cost estimate for the project construction costs. If a construction project is anticipated to be completed in phases, the total estimated cost of all phases of the project shall be submitted to the ~~commissioner~~ commissioners and shall be considered as one construction project. Once the construction project is completed and prior to the final clearance by the ~~commissioner~~

commissioners, the total project construction costs for the construction project shall be submitted to the ~~commissioner~~ commissioners. If the final project construction cost exceeds the dollar threshold in this subdivision, the commissioner of human services shall not recognize any of the project construction costs or the related financing costs in excess of this threshold in establishing the facility's property-related payment rate.

The dollar thresholds for construction projects are as follows: for construction projects other than those authorized in clauses (1) to (6), the dollar threshold is $1,000,000. For projects authorized after July 1, 1993, under clause (1), the dollar threshold is the cost estimate submitted with a proposal for an exception under section 144A.073, plus inflation as calculated according to section 256B.431, subdivision 3f, paragraph (a). For projects authorized under clauses (2) to (4), the dollar threshold is the itemized estimate project construction costs submitted to the commissioner of health at the time of final plan approval, plus inflation as calculated according to section 256B.431, subdivision 3f, paragraph (a).

The commissioner of health shall adopt rules to implement this section or to amend the emergency rules for granting exceptions to the moratorium on nursing homes under section 144A.073.

Sec. 6. Minnesota Statutes 2018, section 144A.071, subdivision 3, is amended to read:

Subd. 3. **Exceptions authorizing increase in beds; hardship areas.** (a) The commissioner of health, in coordination with the commissioner of human services, may approve the addition of new licensed and Medicare and Medicaid certified nursing home beds, using the criteria and process set forth in this subdivision.

(b) The commissioner, in cooperation with the commissioner of human services, shall consider the following criteria when determining that an area of the state is a hardship area with regard to access to nursing facility services:

(1) a low number of beds per thousand in a specified area using as a standard the beds per thousand people age 65 and older, in five year age groups, using data from the most recent census and population projections, weighted by each group's most recent nursing home utilization, of the county at the 20th percentile, as determined by the commissioner of human services;

(2) a high level of out-migration for nursing facility services associated with a described area from the county or counties of residence to other Minnesota counties, as determined by the commissioner of human services, using as a standard an amount greater than the out-migration of the county ranked at the 50th percentile;

(3) an adequate level of availability of noninstitutional long-term care services measured as public spending for home and community-based long-term care services per individual age 65 and older, in five year age groups, using data from the most recent census and population projections, weighted by each group's most recent nursing home utilization, as determined by the commissioner of human services using as a standard an amount greater than the 50th percentile of counties;

(4) there must be a declaration of hardship resulting from insufficient access to nursing home beds by local county agencies and area agencies on aging; and

(5) other factors that may demonstrate the need to add new nursing facility beds.

(c) On August 15 of odd-numbered years, the commissioner, in cooperation with the commissioner of human services, may publish in the State Register a request for information in which interested parties, using the data provided under section 144A.351, along with any other relevant data, demonstrate that a specified area is a hardship area with regard to access to nursing facility services. For a response to be considered, the commissioner must receive it by November 15. The commissioner shall make responses to the request for information available to the public and shall allow 30 days for comment. The commissioner shall review responses and comments and determine if any areas of the state are to be declared hardship areas.

(d) For each designated hardship area determined in paragraph (c), the commissioner shall publish a request for proposals in accordance with section 144A.073 and Minnesota Rules, parts 4655.1070 to 4655.1098. The request for proposals must be published in the State Register by March 15 following receipt of responses to the request for information. The request for proposals must specify the number of new beds which may be added in the designated hardship area, which must not exceed the number which, if added to the existing number of beds in the area, including beds in layaway status, would have prevented it from being determined to be a hardship area under paragraph (b), clause (1). Beginning July 1, 2011, the number of new beds approved must not exceed 200 beds statewide per biennium. After June 30, 2019, the number of new beds that may be approved in a biennium must not exceed 300 statewide. For a proposal to be considered, the commissioner must receive it within six months of the publication of the request for proposals. The commissioner shall review responses to the request for proposals and shall approve or disapprove each proposal by the following July 15, in accordance with section 144A.073 and Minnesota Rules, parts 4655.1070 to 4655.1098. The commissioner shall base approvals or disapprovals on a comparison and ranking of proposals using only the criteria in subdivision 4a. Approval of a proposal expires after 18 months unless the facility has added the new beds using existing

space, subject to approval by the commissioner, or has commenced construction as defined in subdivision 1a, paragraph (d). If, after the approved beds have been added, fewer than 50 percent of the beds in a facility are newly licensed, the operating payment rates previously in effect shall remain. If, after the approved beds have been added, 50 percent or more of the beds in a facility are newly licensed, operating and external fixed payment rates shall be determined according to ~~Minnesota Rules, part 9549.0057, using the limits under sections 256R.23, subdivision 5, and 256R.24, subdivision 3. External fixed costs payment rates must be determined according to section 256R.25~~ section 256R.21, subdivision 5. Property payment rates for facilities with beds added under this subdivision must be determined ~~in the same manner as rate determinations resulting from projects approved and completed under section 144A.073~~ under section 256R.26.

(e) The commissioner may:

(1) certify or license new beds in a new facility that is to be operated by the commissioner of veterans affairs or when the costs of constructing and operating the new beds are to be reimbursed by the commissioner of veterans affairs or the United States Veterans Administration; and

(2) license or certify beds in a facility that has been involuntarily delicensed or decertified for participation in the medical assistance program, provided that an application for relicensure or recertification is submitted to the commissioner by an organization that is not a related organization as defined in section 256R.02, subdivision 43, to the prior licensee within 120 days after delicensure or decertification.

EFFECTIVE DATE. This section is effective January 1, 2020.

Sec. 7. Minnesota Statutes 2018, section 144A.071, subdivision 4a, is amended to read:

Subd. 4a. **Exceptions for replacement beds.** It is in the best interest of the state to ensure that nursing homes and boarding care homes continue to meet the physical plant licensing and certification requirements by permitting certain construction projects. Facilities should be maintained in condition to satisfy the physical and emotional needs of residents while allowing the state to maintain control over nursing home expenditure growth.

The commissioner of health in coordination with the commissioner of human services, may approve the renovation, replacement, upgrading, or relocation of a nursing home or boarding care home, under the following conditions:

(a) to license or certify beds in a new facility constructed to replace a facility or to make repairs in an existing facility that was destroyed or damaged after June 30, 1987, by fire, lightning, or other hazard provided:

(i) destruction was not caused by the intentional act of or at the direction of a controlling person of the facility;

(ii) at the time the facility was destroyed or damaged the controlling persons of the facility maintained insurance coverage for the type of hazard that occurred in an amount that a reasonable person would conclude was adequate;

(iii) the net proceeds from an insurance settlement for the damages caused by the hazard are applied to the cost of the new facility or repairs;

(iv) the number of licensed and certified beds in the new facility does not exceed the number of licensed and certified beds in the destroyed facility; and

(v) the commissioner determines that the replacement beds are needed to prevent an inadequate supply of beds.

Project construction costs incurred for repairs authorized under this clause shall not be considered in the dollar threshold amount defined in subdivision 2;

(b) to license or certify beds that are moved from one location to another within a nursing home facility, provided the total costs of remodeling performed in conjunction with the relocation of beds does not exceed $1,000,000;

(c) to license or certify beds in a project recommended for approval under section 144A.073;

(d) to license or certify beds that are moved from an existing state nursing home to a different state facility, provided there is no net increase in the number of state nursing home beds;

(e) to certify and license as nursing home beds boarding care beds in a certified boarding care facility if the beds meet the standards for nursing home licensure, or in a facility that was granted an exception to the moratorium under section 144A.073, and if the cost of any remodeling of the facility does not exceed $1,000,000. If boarding care beds are licensed as nursing home beds, the number of boarding care beds in the facility must not increase beyond the number remaining at the time of the upgrade in licensure. The provisions contained in section 144A.073 regarding the upgrading of the facilities do not apply to facilities that satisfy these requirements;

(f) to license and certify up to 40 beds transferred from an existing facility owned and operated by the Amherst H. Wilder Foundation in the city of St. Paul to a new unit at the same location as the existing facility that will serve persons with Alzheimer's disease and other related disorders. The transfer of beds may occur gradually or in stages, provided the total number of beds transferred does not exceed 40. At the time of licensure and certification of a bed or beds in the new unit, the commissioner of health shall delicense and decertify the same number of beds in the existing facility. As a condition of receiving a license or certification under this clause, the facility must make a written commitment to the commissioner of human services that it will not seek to receive an increase in its property-related payment rate as a result of the transfers allowed under this paragraph;

(g) to license and certify nursing home beds to replace currently licensed and certified boarding care beds which may be located either in a remodeled or renovated boarding care or nursing home facility or in a remodeled, renovated, newly constructed, or replacement nursing home facility within the identifiable complex of health care facilities in which the currently licensed boarding care beds are presently located, provided that the number of boarding care beds in the facility or complex are decreased by the number to be licensed as nursing home beds and further provided that, if the total costs of new construction, replacement, remodeling, or renovation exceed ten percent of the appraised value of the facility or $200,000, whichever is less, the facility makes a written commitment to the commissioner of human services that it will not seek to receive an increase in its property-related payment rate by reason of the new construction, replacement, remodeling, or renovation. The provisions contained in section 144A.073 regarding the upgrading of facilities do not apply to facilities that satisfy these requirements;

(h) to license as a nursing home and certify as a nursing facility a facility that is licensed as a boarding care facility but not certified under the medical assistance program, but only if the commissioner of human services certifies to the commissioner of health that licensing the facility as a nursing home and certifying the facility as a nursing facility will result in a net annual savings to the state general fund of $200,000 or more;

(i) to certify, after September 30, 1992, and prior to July 1, 1993, existing nursing home beds in a facility that was licensed and in operation prior to January 1, 1992;

(j) to license and certify new nursing home beds to replace beds in a facility acquired by the Minneapolis Community Development Agency as part of redevelopment activities in a city of the first class, provided the new facility is located within three miles of the site of the old facility. Operating and property costs for the new facility must be determined and allowed under section 256B.431 or 256B.434 or chapter 256R;

(k) to license and certify up to 20 new nursing home beds in a community-operated hospital and attached convalescent and nursing care facility with 40 beds on April 21, 1991, that suspended operation of the hospital in April 1986. The commissioner of human services shall provide the facility with the same per diem property-related payment rate for each additional licensed and certified bed as it will receive for its existing 40 beds;

(l) to license or certify beds in renovation, replacement, or upgrading projects as defined in section 144A.073, subdivision 1, so long as the cumulative total costs of the facility's remodeling projects do not exceed $1,000,000;

(m) to license and certify beds that are moved from one location to another for the purposes of converting up to five four-bed wards to single or double occupancy rooms in a nursing home that, as of January 1, 1993, was county-owned and had a licensed capacity of 115 beds;

(n) to allow a facility that on April 16, 1993, was a 106-bed licensed and certified nursing facility located in Minneapolis to layaway all of its licensed and certified nursing home beds. These beds may be relicensed and recertified in a newly constructed teaching nursing home facility affiliated with a teaching hospital upon approval by the legislature. The proposal must be developed in consultation with the interagency committee on long-term care planning. The beds on layaway status shall have the same status as voluntarily delicensed and decertified beds, except that beds on layaway status remain subject to the surcharge in section 256.9657. This layaway provision expires July 1, 1998;

(o) to allow a project which will be completed in conjunction with an approved moratorium exception project for a nursing home in southern Cass County and which is directly related to that portion of the facility that must be repaired, renovated, or replaced, to correct an emergency plumbing problem for which a state correction order has been issued and which must be corrected by August 31, 1993;

(p) to allow a facility that on April 16, 1993, was a 368-bed licensed and certified nursing facility located in Minneapolis to layaway, upon 30 days prior written notice to the commissioner, up to 30 of the facility's licensed and certified beds by converting three-bed wards to single or double occupancy. Beds on layaway status shall have the same status as voluntarily delicensed and decertified beds except that beds on layaway status remain subject to the surcharge in section 256.9657, remain subject to the license application and renewal fees under section 144A.07 and shall be subject to a $100 per bed reactivation fee. In addition, at any time within three years of the effective date of the layaway, the beds on layaway status may be:

(1) relicensed and recertified upon relocation and reactivation of some or all of the beds to an existing licensed and certified facility or facilities located in Pine River, Brainerd, or International Falls; provided that the total project construction costs related to the relocation of beds from layaway status for any facility receiving relocated beds may not exceed the dollar threshold provided in subdivision 2 unless the construction project has been approved through the moratorium exception process under section 144A.073;

(2) relicensed and recertified, upon reactivation of some or all of the beds within the facility which placed the beds in layaway status, if the commissioner has determined a need for the reactivation of the beds on layaway status.

The property-related payment rate of a facility placing beds on layaway status must be adjusted by the incremental change in its rental per diem after recalculating the rental per diem as provided in section 256B.431, subdivision 3a, paragraph (c). The property-related payment rate for a facility relicensing and recertifying beds from layaway status must be adjusted by the incremental change in its rental per diem after recalculating its rental per diem using the number of beds after the relicensing to establish the facility's capacity day divisor, which shall be effective the first day of the month following the month in which the relicensing and recertification became effective. Any beds remaining on layaway status more than three years after the date the layaway status became effective must be removed from layaway status and immediately delicensed and decertified;

(q) to license and certify beds in a renovation and remodeling project to convert 12 four-bed wards into 24 two-bed rooms, expand space, and add improvements in a nursing home that, as of January 1, 1994, met the following conditions: the nursing home was located in Ramsey County; had a licensed capacity of 154 beds; and had been ranked among the top 15 applicants by the 1993 moratorium exceptions advisory review panel. The total project construction cost estimate for this project must not exceed the cost estimate submitted in connection with the 1993 moratorium exception process;

(r) to license and certify up to 117 beds that are relocated from a licensed and certified 138-bed nursing facility located in St. Paul to a hospital with 130 licensed hospital beds located in South St. Paul, provided that the nursing facility and hospital are owned by the same or a related organization and that prior to the date the relocation is completed the hospital ceases operation of its inpatient hospital services at that hospital. After relocation, the nursing facility's status shall be the same as it was prior to relocation. The nursing facility's property-related payment rate resulting from the project authorized in this paragraph shall become effective no earlier than April 1, 1996. For purposes of calculating the incremental change in the facility's rental per diem resulting from this project, the allowable

appraised value of the nursing facility portion of the existing health care facility physical plant prior to the renovation and relocation may not exceed $2,490,000;

(s) to license and certify two beds in a facility to replace beds that were voluntarily delicensed and decertified on June 28, 1991;

(t) to allow 16 licensed and certified beds located on July 1, 1994, in a 142-bed nursing home and 21-bed boarding care home facility in Minneapolis, notwithstanding the licensure and certification after July 1, 1995, of the Minneapolis facility as a 147-bed nursing home facility after completion of a construction project approved in 1993 under section 144A.073, to be laid away upon 30 days' prior written notice to the commissioner. Beds on layaway status shall have the same status as voluntarily delicensed or decertified beds except that they shall remain subject to the surcharge in section 256.9657. The 16 beds on layaway status may be relicensed as nursing home beds and recertified at any time within five years of the effective date of the layaway upon relocation of some or all of the beds to a licensed and certified facility located in Watertown, provided that the total project construction costs related to the relocation of beds from layaway status for the Watertown facility may not exceed the dollar threshold provided in subdivision 2 unless the construction project has been approved through the moratorium exception process under section 144A.073.

The property-related payment rate of the facility placing beds on layaway status must be adjusted by the incremental change in its rental per diem after recalculating the rental per diem as provided in section 256B.431, subdivision 3a, paragraph (c). The property-related payment rate for the facility relicensing and recertifying beds from layaway status must be adjusted by the incremental change in its rental per diem after recalculating its rental per diem using the number of beds after the relicensing to establish the facility's capacity day divisor, which shall be effective the first day of the month following the month in which the relicensing and recertification became effective. Any beds remaining on layaway status more than five years after the date the layaway status became effective must be removed from layaway status and immediately delicensed and decertified;

(u) to license and certify beds that are moved within an existing area of a facility or to a newly constructed addition which is built for the purpose of eliminating three- and four-bed rooms and adding space for dining, lounge areas, bathing rooms, and ancillary service areas in a nursing home that, as of January 1, 1995, was located in Fridley and had a licensed capacity of 129 beds;

(v) to relocate 36 beds in Crow Wing County and four beds from Hennepin County to a 160-bed facility in Crow Wing County, provided all the affected beds are under common ownership;

(w) to license and certify a total replacement project of up to 49 beds located in Norman County that are relocated from a nursing home destroyed by flood and whose residents were relocated to other nursing homes. The operating cost payment rates for the new nursing facility shall be determined based on the interim and settle-up payment provisions of ~~Minnesota Rules, part 9549.0057,~~ section 256R.27 and the reimbursement provisions of chapter 256R. Property-related reimbursement rates shall be determined under section 256R.26, taking into account any federal or state flood-related loans or grants provided to the facility;

(x) to license and certify to the licensee of a nursing home in Polk County that was destroyed by flood in 1997 replacement projects with a total of up to 129 beds, with at least 25 beds to be located in Polk County and up to 104 beds distributed among up to three other counties. These beds may only be distributed to counties with fewer than the median number of age intensity adjusted beds per thousand, as most recently published by the commissioner of human services. If the licensee chooses to distribute beds outside of Polk County under this paragraph, prior to distributing the beds, the commissioner of health must approve the location in which the licensee plans to distribute the beds. The commissioner of health shall consult with the commissioner of human services prior to approving the location of the proposed beds. The licensee may combine these beds with beds relocated from other nursing facilities as provided in section 144A.073, subdivision 3c. The operating payment rates for the new nursing facilities shall be determined based on the interim and settle-up payment provisions of Minnesota Rules, parts 9549.0010 to 9549.0080. Property-related reimbursement rates shall be determined under section 256R.26. If the replacement beds permitted under this paragraph are combined with beds from other nursing facilities, the rates shall be calculated as the weighted average of rates determined as provided in this paragraph and section 256R.50;

(y) to license and certify beds in a renovation and remodeling project to convert 13 three-bed wards into 13 two-bed rooms and 13 single-bed rooms, expand space, and add improvements in a nursing home that, as of January 1, 1994, met the following conditions: the nursing home was located in Ramsey County, was not owned by a hospital corporation, had a licensed capacity of 64 beds, and had been ranked among the top 15 applicants by the 1993 moratorium exceptions advisory review panel. The total project construction cost

estimate for this project must not exceed the cost estimate submitted in connection with the 1993 moratorium exception process;

(z) to license and certify up to 150 nursing home beds to replace an existing 285 bed nursing facility located in St. Paul. The replacement project shall include both the renovation of existing buildings and the construction of new facilities at the existing site. The reduction in the licensed capacity of the existing facility shall occur during the construction project as beds are taken out of service due to the construction process. Prior to the start of the construction process, the facility shall provide written information to the commissioner of health describing the process for bed reduction, plans for the relocation of residents, and the estimated construction schedule. The relocation of residents shall be in accordance with the provisions of law and rule;

(aa) to allow the commissioner of human services to license an additional 36 beds to provide residential services for the physically disabled under Minnesota Rules, parts 9570.2000 to 9570.3400, in a 198-bed nursing home located in Red Wing, provided that the total number of licensed and certified beds at the facility does not increase;

(bb) to license and certify a new facility in St. Louis County with 44 beds constructed to replace an existing facility in St. Louis County with 31 beds, which has resident rooms on two separate floors and an antiquated elevator that creates safety concerns for residents and prevents nonambulatory residents from residing on the second floor. The project shall include the elimination of three- and four-bed rooms;

(cc) to license and certify four beds in a 16-bed certified boarding care home in Minneapolis to replace beds that were voluntarily delicensed and decertified on or before March 31, 1992. The licensure and certification is conditional upon the facility periodically assessing and adjusting its resident mix and other factors which may contribute to a potential institution for mental disease declaration. The commissioner of human services shall retain the authority to audit the facility at any time and shall require the facility to comply with any requirements necessary to prevent an institution for mental disease declaration, including delicensure and decertification of beds, if necessary;

(dd) to license and certify 72 beds in an existing facility in Mille Lacs County with 80 beds as part of a renovation project. The renovation must include construction of an addition to accommodate ten residents with beginning and midstage dementia in a self-contained living unit; creation of three resident households where dining, activities, and support spaces are located near resident living quarters; designation of four beds for rehabilitation in a self-contained area; designation of 30 private rooms; and other improvements;

(ee) to license and certify beds in a facility that has undergone replacement or remodeling as part of a planned closure under section 256R.40;

(ff) to license and certify a total replacement project of up to 124 beds located in Wilkin County that are in need of relocation from a nursing home significantly damaged by flood. The operating cost payment rates for the new nursing facility shall be determined based on the interim and settle-up payment provisions of ~~Minnesota Rules, part 9549.0057,~~ section 256R.27 and the reimbursement provisions of chapter 256R. Property-related reimbursement rates shall be determined under section 256R.26, taking into account any federal or state flood-related loans or grants provided to the facility;

(gg) to allow the commissioner of human services to license an additional nine beds to provide residential services for the physically disabled under Minnesota Rules, parts 9570.2000 to 9570.3400, in a 240-bed nursing home located in Duluth, provided that the total number of licensed and certified beds at the facility does not increase;

(hh) to license and certify up to 120 new nursing facility beds to replace beds in a facility in Anoka County, which was licensed for 98 beds as of July 1, 2000, provided the new facility is located within four miles of the existing facility and is in Anoka County. Operating and property rates shall be determined and allowed under chapter 256R and Minnesota Rules, parts 9549.0010 to 9549.0080; or

(ii) to transfer up to 98 beds of a 129-licensed bed facility located in Anoka County that, as of March 25, 2001, is in the active process of closing, to a 122-licensed bed nonprofit nursing facility located in the city of Columbia Heights or its affiliate. The transfer is effective when the receiving facility notifies the commissioner in writing of the number of beds accepted. The commissioner shall place all transferred beds on layaway status held in the name of the receiving facility. The layaway adjustment provisions of section 256B.431, subdivision 30, do not apply to this layaway. The receiving facility may only remove the beds from layaway for recertification and relicensure at the receiving facility's current site, or at a newly constructed facility located in Anoka County. The receiving facility must receive statutory authorization before removing these beds from layaway status, or may remove these beds from layaway status if removal from layaway status is part of a moratorium exception project approved by the commissioner under section 144A.073.

Sec. 8. Minnesota Statutes 2018, section 144A.071, subdivision 4c, is amended to read:

Subd. 4c. **Exceptions for replacement beds after June 30, 2003.** (a) The commissioner of health, in coordination with the commissioner of human services, may approve the

renovation, replacement, upgrading, or relocation of a nursing home or boarding care home, under the following conditions:

(1) to license and certify an 80-bed city-owned facility in Nicollet County to be constructed on the site of a new city-owned hospital to replace an existing 85-bed facility attached to a hospital that is also being replaced. The threshold allowed for this project under section 144A.073 shall be the maximum amount available to pay the additional medical assistance costs of the new facility;

(2) to license and certify 29 beds to be added to an existing 69-bed facility in St. Louis County, provided that the 29 beds must be transferred from active or layaway status at an existing facility in St. Louis County that had 235 beds on April 1, 2003.

The licensed capacity at the 235-bed facility must be reduced to 206 beds, but the payment rate at that facility shall not be adjusted as a result of this transfer. The operating payment rate of the facility adding beds after completion of this project shall be the same as it was on the day prior to the day the beds are licensed and certified. This project shall not proceed unless it is approved and financed under the provisions of section 144A.073;

(3) to license and certify a new 60-bed facility in Austin, provided that: (i) 45 of the new beds are transferred from a 45-bed facility in Austin under common ownership that is closed and 15 of the new beds are transferred from a 182-bed facility in Albert Lea under common ownership; (ii) the commissioner of human services is authorized by the 2004 legislature to negotiate budget-neutral planned nursing facility closures; and (iii) money is available from planned closures of facilities under common ownership to make implementation of this clause budget-neutral to the state. The bed capacity of the Albert Lea facility shall be reduced to 167 beds following the transfer. Of the 60 beds at the new facility, 20 beds shall be used for a special care unit for persons with Alzheimer's disease or related dementias;

(4) to license and certify up to 80 beds transferred from an existing state-owned nursing facility in Cass County to a new facility located on the grounds of the Ah-Gwah-Ching campus. The operating cost payment rates for the new facility shall be determined based on the interim and settle-up payment provisions of ~~Minnesota Rules, part 9549.0057,~~ section 256R.27 and the reimbursement provisions of chapter 256R. The property payment rate for the first three years of operation shall be $35 per day. For subsequent years, the property payment rate of $35 per day shall be adjusted for inflation as provided in section 256B.434, subdivision 4, paragraph (c), as long as the facility has a contract under section 256B.434;

(5) to initiate a pilot program to license and certify up to 80 beds transferred from an existing county-owned nursing facility in Steele County relocated to the site of a new acute

care facility as part of the county's Communities for a Lifetime comprehensive plan to create innovative responses to the aging of its population. Upon relocation to the new site, the nursing facility shall delicense 28 beds. The payment rate for external fixed costs for the new facility shall be increased by an amount as calculated according to items (i) to (v):

(i) compute the estimated decrease in medical assistance residents served by the nursing facility by multiplying the decrease in licensed beds by the historical percentage of medical assistance resident days;

(ii) compute the annual savings to the medical assistance program from the delicensure of 28 beds by multiplying the anticipated decrease in medical assistance residents, determined in item (i), by the existing facility's weighted average payment rate multiplied by 365;

(iii) compute the anticipated annual costs for community-based services by multiplying the anticipated decrease in medical assistance residents served by the nursing facility, determined in item (i), by the average monthly elderly waiver service costs for individuals in Steele County multiplied by 12;

(iv) subtract the amount in item (iii) from the amount in item (ii);

(v) divide the amount in item (iv) by an amount equal to the relocated nursing facility's occupancy factor under section 256B.431, subdivision 3f, paragraph (c), multiplied by the historical percentage of medical assistance resident days; and

(6) to consolidate and relocate nursing facility beds to a new site in Goodhue County and to integrate these services with other community-based programs and services under a communities for a lifetime pilot program and comprehensive plan to create innovative responses to the aging of its population. Two nursing facilities, one for 84 beds and one for 65 beds, in the city of Red Wing licensed on July 1, 2015, shall be consolidated into a newly renovated 64-bed nursing facility resulting in the delicensure of 85 beds. Notwithstanding the carryforward of the approval authority in section 144A.073, subdivision 11, the funding approved in April 2009 by the commissioner of health for a project in Goodhue County shall not carry forward. The closure of the 85 beds shall not be eligible for a planned closure rate adjustment under section 256R.40. The construction project permitted in this clause shall not be eligible for a threshold project rate adjustment under section 256B.434, subdivision 4f. The payment rate for external fixed costs for the new facility shall be increased by an amount as calculated according to items (i) to (vi):

(i) compute the estimated decrease in medical assistance residents served by both nursing facilities by multiplying the difference between the occupied beds of the two nursing facilities

for the reporting year ending September 30, 2009, and the projected occupancy of the facility at 95 percent occupancy by the historical percentage of medical assistance resident days;

(ii) compute the annual savings to the medical assistance program from the delicensure by multiplying the anticipated decrease in the medical assistance residents, determined in item (i), by the hospital-owned nursing facility weighted average payment rate multiplied by 365;

(iii) compute the anticipated annual costs for community-based services by multiplying the anticipated decrease in medical assistance residents served by the facilities, determined in item (i), by the average monthly elderly waiver service costs for individuals in Goodhue County multiplied by 12;

(iv) subtract the amount in item (iii) from the amount in item (ii);

(v) multiply the amount in item (iv) by 57.2 percent; and

(vi) divide the difference of the amount in item (iv) and the amount in item (v) by an amount equal to the relocated nursing facility's occupancy factor under section 256B.431, subdivision 3f, paragraph (c), multiplied by the historical percentage of medical assistance resident days.

(b) Projects approved under this subdivision shall be treated in a manner equivalent to projects approved under subdivision 4a.

Sec. 9. Minnesota Statutes 2018, section 144A.071, subdivision 5a, is amended to read:

Subd. 5a. **Cost estimate of a moratorium exception project.** ~~(a)~~ For the purposes of this section and section 144A.073, the cost estimate of a moratorium exception project shall include the effects of the proposed project on the costs of the state subsidy for community-based services, nursing services, and housing in institutional and noninstitutional settings. The commissioner of health, in cooperation with the commissioner of human services, shall define the method for estimating these costs in the permanent rule implementing section 144A.073. The commissioner of human services shall prepare an estimate of the property-related payment rate to be established upon completion of the project and total state annual long-term costs of each moratorium exception proposal. The property-related payment rate estimate shall be made using the actual cost of the project but the final property rate must be based on the appraisal and subject to the limitations in section 256R.26, subdivision 6.

~~(b) The interest rate to be used for estimating the cost of each moratorium exception project proposal shall be the lesser of either the prime rate plus two percentage points, or~~

~~the posted yield for standard conventional fixed rate mortgages of the Federal Home Loan Mortgage Corporation plus two percentage points as published in the Wall Street Journal and in effect 56 days prior to the application deadline. If the applicant's proposal uses this interest rate, the commissioner of human services, in determining the facility's actual property-related payment rate to be established upon completion of the project must use the actual interest rate obtained by the facility for the project's permanent financing up to the maximum permitted under Minnesota Rules, part 9549.0060, subpart 6.~~

~~The applicant may choose an alternate interest rate for estimating the project's cost. If the applicant makes this election, the commissioner of human services, in determining the facility's actual property-related payment rate to be established upon completion of the project, must use the lesser of the actual interest rate obtained for the project's permanent financing or the interest rate which was used to estimate the proposal's project cost. For succeeding rate years, the applicant is at risk for financing costs in excess of the interest rate selected.~~

EFFECTIVE DATE. This section is effective January 1, 2020.

Sec. 10. Minnesota Statutes 2018, section 144A.073, subdivision 3c, is amended to read:

Subd. 3c. ~~**Cost neutral**~~ **Relocation projects.** ~~(a)~~ Notwithstanding subdivision 3, the commissioner may at any time accept proposals, or amendments to proposals previously approved under this section, for relocations ~~that are cost neutral with respect to state costs as defined in section 144A.071, subdivision 5a~~. The commissioner, in consultation with the commissioner of human services, shall evaluate proposals according to subdivision 4a, clauses (1), (4), (5), (6), and (8), and other criteria established in rule or law. ~~The commissioner of human services shall determine the allowable payment rates of the facility receiving the beds in accordance with section 256R.50.~~ The commissioner shall approve or disapprove a project within 90 days.

~~(b) For the purposes of paragraph (a), cost neutrality shall be measured over the first three 12-month periods of operation after completion of the project.~~

EFFECTIVE DATE. This section is effective January 1, 2020.

Sec. 11. Minnesota Statutes 2018, section 256R.02, subdivision 8, is amended to read:

Subd. 8. **Capital assets.** "Capital assets" means a nursing facility's buildings, ~~attached fixtures~~ fixed equipment, land improvements, leasehold improvements, and all additions to or replacements of those assets used directly for resident care.

Sec. 12. Minnesota Statutes 2018, section 256R.02, subdivision 19, is amended to read:

Subd. 19. **External fixed costs.** "External fixed costs" means costs related to the nursing home surcharge under section 256.9657, subdivision 1; licensure fees under section 144.122; family advisory council fee under section 144A.33; scholarships under section 256R.37; ~~planned closure rate adjustments under section 256R.40; consolidation rate adjustments under section 144A.071, subdivisions 4c, paragraph (a), clauses (5) and (6), and 4d; single-bed room incentives under section 256R.41;~~ property taxes, special assessments, and payments in lieu of taxes; employer health insurance costs; quality improvement incentive payment rate adjustments under section 256R.39; performance-based incentive payments under section 256R.38; special dietary needs under section 256R.51; rate adjustments for compensation-related costs for minimum wage changes under section 256R.49 provided on or after January 1, 2018; and Public Employees Retirement Association employer costs.

EFFECTIVE DATE. This section is effective January 1, 2020.

Sec. 13. Minnesota Statutes 2018, section 256R.16, subdivision 1, is amended to read:

Subdivision 1. **Calculation of a quality score.** (a) The commissioner shall determine a quality score for each nursing facility using quality measures established in section 256B.439, according to methods determined by the commissioner in consultation with stakeholders and experts, and using the most recently available data as provided in the Minnesota Nursing Home Report Card. These methods shall be exempt from the rulemaking requirements under chapter 14.

(b) For each quality measure, a score shall be determined with the number of points assigned as determined by the commissioner using the methodology established according to this subdivision. The determination of the quality measures to be used and the methods of calculating scores may be revised annually by the commissioner.

(c) The quality score shall include up to 50 points related to the Minnesota quality indicators score derived from the minimum data set, up to 40 points related to the resident quality of life score derived from the consumer survey conducted under section 256B.439, subdivision 3, and up to ten points related to the state inspection results score.

(d) The commissioner, in cooperation with the commissioner of health, may adjust the formula in paragraph (c), or the methodology for computing the total quality score, ~~effective July 1 of any year,~~ with five months advance public notice. In changing the formula, the commissioner shall consider quality measure priorities registered by report card users, advice of stakeholders, and available research.

Sec. 14. Minnesota Statutes 2018, section 256R.21, is amended by adding a subdivision to read:

Subd. 5. **Total payment rate for new facilities.** For a new nursing facility created under section 144A.073, subdivision 3c, the total payment rate must be determined according to this section, except:

(1) the direct care payment rate used in subdivision 2, clause (1), must be determined according to section 256R.27;

(2) the other care-related payment rate used in subdivision 2, clause (2), must be determined according to section 256R.27;

(3) the external fixed costs payment rate used in subdivision 4, clause (2), must be determined according to section 256R.27; and

(4) the property payment rate used in subdivision 4, clause (3), must be determined according to section 256R.26.

EFFECTIVE DATE. This section is effective January 1, 2020.

Sec. 15. Minnesota Statutes 2018, section 256R.23, subdivision 5, is amended to read:

Subd. 5. **Determination of total care-related payment rate limits.** The commissioner must determine each facility's total care-related payment rate limit by:

(1) multiplying the facility's quality score, as determined under section 256R.16, subdivision 1, paragraph (d), by ~~0.5625~~ 2.0;

(2) ~~adding 89.375 to~~ subtracting 40.0 from the amount determined in clause (1), and dividing the total by 100; ~~and~~

(3) multiplying the amount determined in clause (2) by the median total care-related cost per day~~.~~; and

(4) multiplying the amount determined in clause (3) by the most-recent available Core-Based Statistical Area wage indices established by the Centers for Medicare and Medicaid Services for the Skilled Nursing Facility Prospective Payment System.

EFFECTIVE DATE. This section is effective January 1, 2020.

Sec. 16. Minnesota Statutes 2018, section 256R.24, subdivision 3, is amended to read:

Subd. 3. **Determination of the other operating payment rate.** A facility's other operating payment rate equals the lesser of (1) 105 percent of the median other operating

cost per day as determined by subdivisions 1 and 2, or (2) the prior year operating payment rate adjusted by a forecasting market basket and forecasting index. The adjustment factor shall come from the Information Handling Services Healthcare Cost Review, the Skilled Nursing Facility Total Market Basket Index, and the four-quarter moving average percentage change line or a comparable index if this index ceases to be published. The commissioner shall use the fourth quarter index of the upcoming calendar year from the forecast published for the third quarter of the calendar year immediately prior to the rate year for which the rate is being determined.

Sec. 17. Minnesota Statutes 2018, section 256R.25, is amended to read:

256R.25 EXTERNAL FIXED COSTS PAYMENT RATE.

(a) The payment rate for external fixed costs is the sum of the amounts in paragraphs (b) to ~~(n)~~ (k).

(b) For a facility licensed as a nursing home, the portion related to the provider surcharge under section 256.9657 is equal to $8.86 per resident day. For a facility licensed as both a nursing home and a boarding care home, the portion related to the provider surcharge under section 256.9657 is equal to $8.86 per resident day multiplied by the result of its number of nursing home beds divided by its total number of licensed beds.

(c) The portion related to the licensure fee under section 144.122, paragraph (d), is the amount of the fee divided by the sum of the facility's resident days.

(d) The portion related to development and education of resident and family advisory councils under section 144A.33 is $5 per resident day divided by 365.

(e) The portion related to scholarships is determined under section 256R.37.

~~(f) The portion related to planned closure rate adjustments is as determined under section 256R.40, subdivision 5, and Minnesota Statutes 2010, section 256B.436.~~

~~(g) The portion related to consolidation rate adjustments shall be as determined under section 144A.071, subdivisions 4c, paragraph (a), clauses (5) and (6), and 4d.~~

~~(h) The portion related to single-bed room incentives is as determined under section 256R.41.~~

~~(i)~~ (f) The portions related to real estate taxes, special assessments, and payments made in lieu of real estate taxes directly identified or allocated to the nursing facility are the ~~actual~~ allowable amounts divided by the sum of the facility's resident days. Allowable costs under this paragraph for payments made by a nonprofit nursing facility that are in lieu of real

estate taxes shall not exceed the amount which the nursing facility would have paid to a city or township and county for fire, police, sanitation services, and road maintenance costs had real estate taxes been levied on that property for those purposes.

~~(j)~~ (g) The portion related to employer health insurance costs is the allowable costs divided by the sum of the facility's resident days.

~~(k)~~ (h) The portion related to the Public Employees Retirement Association is ~~actual~~ allowable costs divided by the sum of the facility's resident days.

~~(l)~~ (i) The portion related to quality improvement incentive payment rate adjustments is the amount determined under section 256R.39.

~~(m)~~ (j) The portion related to performance-based incentive payments is the amount determined under section 256R.38.

~~(n)~~ (k) The portion related to special dietary needs is the amount determined under section 256R.51.

EFFECTIVE DATE. This section is effective January, 1, 2020.

Sec. 18. Minnesota Statutes 2018, section 256R.26, is amended to read:

256R.26 PROPERTY PAYMENT RATE.

Subdivision 1. **Generally.** ~~The property payment rate for a nursing facility is the property rate established for the facility under sections 256B.431 and 256B.434.~~ (a) For rate years beginning on or after January 1, 2020, the commissioner shall reimburse nursing facilities participating in the medical assistance program for the rental use of real estate and depreciable assets according to this section and sections 256R.261 to 256R.27. The property payment rate made under this methodology is the only payment for costs related to capital assets, including depreciation, interest and lease expenses for all depreciable assets, also including movable equipment, land improvements, and land.

(b) The commercial valuation system selected by the commissioner must be utilized in all appraisals. The appraisal is not intended to exactly reflect market value, and no adjustments or substitutions are permitted for any alternative analysis of properties than the selected commercial valuation system.

(c) Based on the valuation of a building and fixed equipment, the property appraisal firm selected by the commissioner must produce a report detailing both the depreciated replacement cost (DRC) and undepreciated replacement cost (URC) of the nursing facility. The valuation excludes movable equipment, land, or land improvements. The valuation

must be adjusted for any shared area included in the DRC and URC not used for nursing facility purposes. Physical plant for central office operations is not included in the appraisal.

(d) The appraisal initially may include the full value of all shared areas. The DRC, URC, and square footage are established by an appraisal and must be adjusted to reflect only the nursing facility usage of shared areas in the final nursing facility values. The adjustment must be based on a Medicare-approved allocation basis for the type of service provided by each area. Shared areas outside the appraised space must be added to the DRC, URC, and related square footage using the average of each value from the space in the appraisal.

Subd. 2. **Appraised value.** For rate years beginning on or after January 1, 2020, the DRC and URC are based on the appraisals of a building and attached fixtures as determined by the contracted property appraisal firm using a commercial valuation system selected by the commissioner.

Subd. 3. **Initial rate year.** The property payment rate calculated under section 256R.265 for the initial rate year effective January 1, 2020, must be a per diem amount based on the DRC and URC of a nursing facility's building and attached fixtures, as estimated by a commercial property appraisal firm in 2016. The initial values for both the DRC and URC, adjusted for nonnursing facility space, must be increased by six percent.

Subd. 4. **Subsequent rate years.** (a) Beginning in calendar year 2020, the commissioner shall contract with a property appraisal firm to appraise the building and attached fixtures for nursing facilities using the commercial valuation system. Approximately one-third of the nursing facilities must be appraised each year.

(b) If a nursing facility wishes to appeal findings of fact in the appraisal report, the nursing facility must request a revision within 20 calendar days after receipt of the appraisal report.

(c) The property payment rate for rate year beginning January 1, 2021, for the one-third of nursing facilities that are newly appraised in 2020 must be based upon new DRCs and URCs for buildings and attached fixtures as determined by the contracted property appraisal firm.

(d) The property payment rate for rate years beginning January 1, 2021, and January 1, 2022, for the remainder of the nursing facilities that were not previously appraised, must use the net DRC and URC used in the January 1, 2020, property payment rates adjusted for inflation before any formula limitations are applied. The index for the inflation adjustment must be based on the change in the United States All-Items Consumer Price Index (CPI-U) forecasted by the Reports and Forecasts Division of the Department of Human Services in

the third quarter of the calendar year preceding the rate year. The inflation adjustment must be based on the 12-month period from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined. Nursing facilities under this paragraph must have the property payment rates beginning January 1, 2022, and January 1, 2023, based on new replacement costs and depreciated values as determined in appraisals based on the three-year cycle.

(e) For the nursing facility's new physical appraisal after the nursing facility's 2016 appraisal, the most recent DRC and URC must be updated through the commercial valuation system. These valuations are updates only and not subject to revisions of any of the original valuations or appeal by the nursing facility.

Subd. 5. **Special reappraisals.** (a) A nursing facility that completes an addition to or replacement of a building or attached fixtures as approved in section 144A.073 after January 1, 2020, may request a property rate adjustment effective the first of January, April, July, or October after project completion. The nursing facility must submit all cost data related to the project to the commissioner within 90 days of project completion. The commissioner must add the nursing facility to the next group of scheduled appraisals. The nursing facility's updated appraisal must be used to calculate a revised property rate effective the first of January, April, July, or October after project completion. If an updated appraisal cannot be scheduled within 90 days of the effective date of the revised property, the commissioner must establish an interim valuation which must be adjusted retroactively when the updated appraisal is available. For a nursing facility with projects approved under section 144A.073 prior to January 1, 2020, moratorium project construction adjustments must be calculated under Minnesota Statutes 2018, section 256B.434, subdivision 4f, and the adjustment added to the nursing facility's hold harmless rate effective the first of January, April, July, or October after project completion. This adjustment is in addition to the updated appraisal described in this paragraph.

(b) A nursing facility that completes a threshold construction project after January 1, 2020, may submit a project rate adjustment request to the commissioner if the building improvement or addition costs exceed $300,000 and the threshold construction project is not reflected in an appraisal used for rate setting. The cost must be incurred by the nursing facility, or if the nursing facility is leased and the cost is incurred by the lease holder, the provider's lease has been increased for the project. Threshold project costs exceeding a total of $1,500,000 within a three-year period, or a prorated amount if the appraisals are less than three years apart, must not be recognized. The property payment rate must be updated to reflect the new DRC and URC values effective the first of January or July after project

completion. In subsequent property payment rate calculations, an addition to the DRC and URC must be eliminated once a full appraisal is complete for the nursing facility after project completion. At the option of the commissioner the appraisal schedule may be adjusted for nursing facilities completing threshold projects. Threshold project costs are not considered if the costs were incurred prior to the date of the last appraisal.

(c) Effective January 1, 2020, a nursing facility new to the medical assistance program must have the building and fixed equipment appraised by the property appraisal firm upon completion of construction of the nursing facility, or, if not newly constructed, upon entering the medical assistance program. If an appraisal cannot be scheduled within 90 days of the certification date, the commissioner must establish an interim valuation to be adjusted retroactively when the appraisal is available.

Subd. 6. **Limitation on appraisal valuations.** Effective for appraisals conducted on or after January 1, 2020, the increase in the URC is limited to $500,000 per year since the last completed appraisal plus any completed project costs approved under section 144A.073. Any limitation to the URC must be applied in the same proportion to the DRC.

Subd. 7. **Total hold harmless rate.** (a) Total hold harmless rate includes closure adjustments under Minnesota Statutes 2018, section 256R.40, subdivision 5; consolidation adjustments under section 144A.071, subdivisions 4c, paragraph (a), clauses (5) and (6), and 4d; equity incentives under sections 256B.431, subdivision 16, and Minnesota Statutes 2018, 256B.434, subdivision 4f; single-bed incentives under Minnesota Statutes 2018, section 256R.41; project construction costs under Minnesota Statutes 2018, section 144A.071, subdivision 1a, paragraph (j); and all components of the property payment rate under section 256R.26 in effect on December 31, 2019.

(b) For moratorium projects as defined under sections 144A.071 and 144A.073 that are eligible for rate adjustments approved prior to January 1, 2020, but not reflected in the rate on December 31, 2019, the moratorium rate adjustments determined under Minnesota Statutes 2018, sections 256B.431, subdivisions 3f, 17, 17a, 17c, 17d, 17e, 21, 30, and 45, and 256B.434, subdivisions 4f and 4j, must be added to the total hold harmless rate in effect on the first of January, April, July, or October after project completion.

(c) Effective January 1, 2020, rate adjustments under Minnesota Statutes 2018, section 256R.25, paragraphs (f) to (h) from previous rate years shall be included in the total hold harmless rate.

Subd. 8. **Phase out of hold harmless rate.** (a) For a nursing facility that has a higher total hold harmless rate than the rate calculated in section 256R.265, the nursing facility

must receive 100 percent of the total hold harmless rate for the rate year beginning January 1, 2020.

(b) For rate years beginning January 1, 2021, to January 1, 2024, the property payment rate is a blending of the total hold harmless rate and the property rate determined in section 256R.265, plus any adjustments issued for construction projects between appraisals, if a higher rate results. If not, the property payment rate is determined according to section 256R.265.

(c) For the rate year beginning January 1, 2021, for eligible nursing facilities, the property payment rate is 80 percent of the total hold harmless rate and 20 percent of the property payment rate calculated in section 256R.265.

(d) For the rate year beginning January 1, 2022, for eligible nursing facilities, the property payment rate is 60 percent of the total hold harmless rate and 40 percent of the property payment rate calculated in section 256R.265.

(e) For the rate year beginning January 1, 2023, for eligible nursing facilities, the property payment rate is 40 percent of the total hold harmless rate and 60 percent of the property payment rate calculated in section 256R.265.

(f) For the rate year beginning January 1, 2024, for eligible nursing facilities, the property payment rate is 20 percent of the total hold harmless rate and 80 percent of the property payment rate calculated in section 256R.265.

(g) For rate years beginning January 1, 2025, and thereafter, the property payment rate is as calculated under section 256R.265.

Sec. 19. **[256R.261] NURSING FACILITY PROPERTY RATE DEFINITIONS.**

Subdivision 1. **Definitions.** For purposes of sections 256R.26 to 256R.27, the following terms have the meanings given them.

Subd. 2. **Addition.** "Addition" means an extension, enlargement, or expansion of the nursing facility for the purpose of increasing the number of licensed beds or improving resident care.

Subd. 3. **Appraisal.** "Appraisal" means an evaluation of the nursing facility's physical real estate conducted by a property appraisal firm selected by the commissioner to establish the valuation of a building and fixed equipment.

Subd. 4. **Building.** "Building" means the physical plant and fixed equipment used directly for resident care and licensed under chapter 144A or sections 144.50 to 144.56. Building excludes buildings or portions of buildings used by central, affiliated, or corporate offices.

Subd. 5. **Commercial valuation system.** "Commercial valuation system" means a commercially available building valuation system selected by the commissioner that may include the Marshall and Swift Valuation System.

Subd. 6. **Depreciable movable equipment.** "Depreciable movable equipment" means the standard movable care equipment and support service equipment generally used in nursing facilities. Depreciable movable equipment includes equipment specified in the major movable equipment table of the depreciation guidelines. The general characteristics of this equipment are: (1) a relatively fixed location in the building; (2) capable of being moved as distinguished from building equipment; (3) a unit cost sufficient to justify ledger control; and (4) sufficient size and identity to make control feasible by means of identification tags.

Subd. 7. **Depreciated replacement cost or DRC.** "Depreciated replacement cost" or "DRC" means the depreciated replacement cost determined by an appraisal using the commercial valuation system. DRC excludes costs related to parking structures.

Subd. 8. **Depreciation expense.** "Depreciation expense" means the portion of a capital asset deemed to be consumed or expired over the life of the asset.

Subd. 9. **Depreciation guidelines.** "Depreciation guidelines" means the most recent publication of "Estimated Useful Lives of Depreciable Hospital Assets" issued by the American Hospital Association.

Subd. 10. **Equipment allowance.** "Equipment allowance" means the component of the property-related payment rate which is a payment for the use of depreciable movable equipment.

Subd. 11. **Fair rental value system.** "Fair rental value system" means a system that establishes a price for the use of a space based on an appraised value of the property. The price is established without consideration of the actual accounting cost to construct or remodel the property. The price is the nursing facility value, subject to limits, multiplied by an established rental rate.

Subd. 12. **Fixed equipment.** "Fixed equipment" means equipment affixed to the building and not subject to transfer, including but not limited to wiring, electrical fixtures, plumbing, elevators, and heating and air conditioning systems.

Subd. 13. **Land improvement.** "Land improvement" means improvement to the land surrounding the nursing facility directly used for nursing facility operations as specified in the land improvements table of the depreciation guidelines. Land improvement includes construction of auxiliary buildings including sheds, garages, storage buildings, and parking structures.

Subd. 14. **Rental rate.** "Rental rate" means the percentage applied to the allowable value of the building and attached fixtures per year in the property payment calculation as determined by the commissioner.

Subd. 15. **Shared area.** "Shared area" means square footage that a nursing facility shares with a non-nursing facility operation to provide a support service.

Subd. 16. **Threshold project.** "Threshold project" means additions to a building or fixed equipment that exceed the costs specified in section 256R.26, subdivision 5, paragraph (b). Threshold projects exclude land, land improvements, and movable equipment purchases.

Subd. 17. **Undepreciated replacement cost or URC.** "Undepreciated replacement cost" or "URC" means the undepreciated replacement cost determined by the appraisal for building and attached fixtures using a commercial valuation system. URC excludes costs related to parking structures.

Subd. 18. **Undepreciated replacement cost (URC) per bed limit.** "Undepreciated replacement cost (URC) per bed limit" means the maximum allowed URC per nursing facility bed as established by the commissioner based on values across the industry and compared to an industry standard for reasonableness.

Sec. 20. **[256R.265] PROPERTY RATE CALCULATION UNDER FAIR RENTAL VALUE SYSTEM.**

Subdivision 1. **Square feet per bed limit.** The square feet per bed limit is calculated as follows:

(1) the URC of the nursing facility from the appraisal is divided by the allowable nursing facility square feet;

(2) the allowable total square feet is calculated by dividing the actual square feet from the appraisal, after adjustment for non-nursing facility area, by the number of licensed beds three months prior to the beginning of the rate year limited to the following maximum. The allowable square feet maximum is 800 square feet per bed plus 25 percent of the square feet over 800 up to 1,200 square feet per bed. Square feet over 1,200 square feet per bed is not recognized; and

(3) the allowable total square feet in clause (2) is multiplied by the amount in clause (1) and by the number of licensed beds three months prior to the beginning of the rate year to determine the square feet per bed limit.

Subd. 2. **Total URC limit.** The total URC limit is calculated as follows:

(1) the allowable square feet per bed limit as determined in subdivision 1 is divided by the number of licensed beds three months prior to the beginning of the rate year to determine allowable URC per bed limit for each nursing facility, adjusted for square feet limitation;

(2) the allowable URC per bed limit, adjusted for square feet limitation, for all nursing facilities is placed in an array annually to determine the value at the 75th percentile. This is the limit for URC per bed limit for non-single beds;

(3) the value determined in clause (2) is multiplied by 115 percent to determine the limit for URC per bed limit for single beds;

(4) the number of non-single-licensed beds three months prior to the beginning of the rate year is multiplied by the amount in clause (2);

(5) the number of single-licensed beds three months prior to the beginning of the rate year is multiplied by the amount in clause (3); and

(6) the amounts in clauses (4) and (5) are summed to determine the total URC limit;

Subd. 3. **Calculation of total property rate.** The total property rate is calculated as follows:

(1) the lower of the allowable URC based on square feet per bed limit as determined under subdivision 1 or the total URC limit in subdivision 2 is the final allowed URC;

(2) the final allowed URC determined in clause (1) is divided by the URC from the appraisal to determine the allowed percentage. The allowed percentage is multiplied by the depreciated replacement value from the appraisal, adjusted for non-nursing facility area, to determine the final allowed depreciated replacement value;

(3) the number of licensed beds three months prior to the beginning of the rate year is multiplied by $5,305 to determine reimbursement for land and land improvements. There is no separate addition to the property rate for parking structures;

(4) the values in clauses (2) and (3) are summed and then multiplied by the rental rate of 5.5 percent to determine allowable property reimbursement;

(5) the allowable property reimbursement determined in clause (4) is divided by 90 percent of capacity days to determine the building property rate. Capacity days are determined

by multiplying the number of licensed beds three months prior to the beginning of the report year by 365;

(6) for the rate year beginning January 1, 2020, the equipment allowance is $2.77 per resident day. For the rate year beginning January 1, 2021, the equipment allowance must be adjusted annually for inflation. The index for the inflation adjustment must be based on the change in the United States All Items Consumer Price Index (CPI-U) forecasted by the Reports and Forecasts Division of the Department of Human Services in the third quarter of the calendar year preceding the rate year. The inflation adjustment must be based on the 12-month period from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined; and

(7) the sum of the building property rate and the equipment allowance is the total property rate.

Sec. 21. **[256R.27] INTERIM AND SETTLE UP TOTAL OPERATING AND EXTERNAL FIXED COST PAYMENT RATES.**

Subdivision 1. **Generally.** (a) A newly constructed nursing facility, or a nursing facility with a capacity increase of 50 percent or more, must receive an interim total operating rate payment and settle up total operating cost payment according to this section.

(b) The nursing facility shall submit a written application to the commissioner to receive an interim total operating payment rate. In its application, the nursing facility shall state any reasons for noncompliance with this chapter.

(c) The effective date of the interim total operating payment rate is the earlier of either the first day a resident is admitted to the newly constructed nursing facility or the date the nursing facility bed is certified for the medical assistance program. The interim total operating payment rate must not be in effect more than 17 months.

(d) The nursing facility must continue to receive the interim total operating payment rate until the settle up total operating cost payment is determined under subdivision 3.

(e) The settle up total operating cost payment rate is effective retroactively to the beginning of the interim cost report period, and is effective until the end of the interim rate period.

(f) For the 15-month period following the settle up reporting period, the total operating rate payment and external fixed cost payment rate must be determined according to subdivision 3, paragraph (b).

(g) The total operating rate payment and external fixed cost payment rate for the rate year beginning January 1 following the 15-month period in paragraph (f) must be determined under this chapter.

(h) The commissioner shall determine interim total operating cost payment rates and settle up total operating cost payment rates for a newly constructed nursing facility, or a nursing facility with an increase in licensed capacity of 50 percent or more, according to subdivisions 2 and 3.

Subd. 2. **Determination of interim operating and external fixed cost payment rate.** (a) The nursing facility shall submit an interim cost report in a format similar to the Minnesota Statistical and Cost Report and other supporting information as required by this chapter for the reporting year in which the nursing facility plans to begin operation at least 60 days before the first day a resident is admitted to the newly constructed nursing facility bed. The interim cost report must include the nursing facility's anticipated interim costs and anticipated interim resident days for each resident class in the interim cost report. The anticipated interim resident days for each resident class is multiplied by the weight for that resident class to determine the anticipated interim standardized days as defined in section 256R.02, subdivision 50, and resident days as defined in section 256R.02, subdivision 45, for the reporting period.

(b) The interim total operating cost payment rate is determined according to this section, except that:

(1) the anticipated interim costs and anticipated interim resident days reported on the interim cost report and the anticipated interim standardized days as defined by section 256R.02, subdivision 50, must be used for the interim;

(2) the commissioner shall use anticipated interim costs and anticipated interim standardized days in determining the allowable historical direct care cost per standardized day as determined under section 256R.23, subdivision 2;

(3) the commissioner shall use anticipated interim costs and anticipated interim resident days in determining the allowable historical other care-related cost per resident day as determined under section 256R.23, subdivision 3;

(4) the commissioner shall use anticipated interim costs and anticipated interim resident days to determine the allowable historical external fixed cost per day under section 256R.25, paragraphs (b) to (k);

(5) the total care-related payment rate limits established in section 256R.23, subdivision 5, and in effect at the beginning of the interim period, must be increased by ten percent; and

(6) the other operating payment rate as determined under section 256R.24 in effect for the rate year must be used for the other operating cost per day.

Subd. 3. **Determination of settle up operating and external fixed cost payment rate.** (a) When the interim payment rate begins between May 1 and September 30, the nursing facility shall file settle up cost reports for the period from the beginning of the interim payment rate through September 30 of the following year.

(b) When the interim payment rate begins between October 1 and April 30, the nursing facility shall file settle up cost reports for the period from the beginning of the interim payment rate to the first September 30 following the beginning of the interim payment rate.

(c) The settle up total operating cost payment rate is determined according to this section, except that:

(1) the allowable costs and resident days reported on the settle up cost report and the standardized days as defined by section 256R.02, subdivision 50, must be used for the interim and settle-up period;

(2) the commissioner shall use the allowable costs and standardized days in clause (1) to determine the allowable historical direct care cost per standardized day as determined under section 256R.23, subdivision 2;

(3) the commissioner shall use the allowable costs and the allowable resident days to determine both the allowable historical other care-related cost per resident day as determined under section 256R.23, subdivision 3;

(4) the commissioner shall use the allowable costs and the allowable resident days to determine the allowable historical external fixed cost per day under section 256R.25, paragraphs (b) to (k);

(5) the total care-related payment limits established in section 256R.23, subdivision 5, are the limits for the settle up reporting periods. If the interim period includes more than one July 1 date, the commissioner shall use the total care-related payment limit established in section 256R.23, subdivision 5, increased by ten percent for the second July 1 date; and

(6) the other operating payment rate as determined under section 256R.24 in effect for the rate year must be used for the other operating cost per day.

Sec. 22. Minnesota Statutes 2018, section 256R.44, is amended to read:

256R.44 RATE ADJUSTMENT FOR PRIVATE ROOMS FOR MEDICAL NECESSITY.

The amount paid for a private room is ~~111.5~~ 110 percent of the established total payment rate for a resident if the resident is a medical assistance recipient and the private room is considered a medical necessity for the resident or others who are affected by the resident's condition~~, except as provided in Minnesota Rules, part 9549.0060, subpart 11, item C~~. Conditions requiring a private room must be determined by the resident's attending physician and submitted to the commissioner for approval or denial by the commissioner on the basis of medical necessity.

EFFECTIVE DATE. This section is effective January 1, 2020.

Sec. 23. Minnesota Statutes 2018, section 256R.47, is amended to read:

256R.47 RATE ADJUSTMENT FOR CRITICAL ACCESS NURSING FACILITIES.

(a) The commissioner, in consultation with the commissioner of health, may designate certain nursing facilities as critical access nursing facilities. The designation shall be granted on a competitive basis, within the limits of funds appropriated for this purpose.

(b) The commissioner shall request proposals from nursing facilities every two years. Proposals must be submitted in the form and according to the timelines established by the commissioner. In selecting applicants to designate, the commissioner, in consultation with the commissioner of health, and with input from stakeholders, shall develop criteria designed to preserve access to nursing facility services in isolated areas, rebalance long-term care, and improve quality. To the extent practicable, the commissioner shall ensure an even distribution of designations across the state.

(c) The commissioner shall allow the benefits in clauses (1) to (5) for nursing facilities designated as critical access nursing facilities:

(1) partial rebasing, with the commissioner allowing a designated facility operating payment rates being the sum of up to 60 percent of the operating payment rate determined in accordance with section 256R.21, subdivision 3, and at least 40 percent, with the sum of the two portions being equal to 100 percent, of the operating payment rate that would have been allowed had the facility not been designated. The commissioner may adjust these percentages by up to 20 percent and may approve a request for less than the amount allowed;

(2) enhanced payments for leave days. Notwithstanding section 256R.43, upon designation as a critical access nursing facility, the commissioner shall limit payment for leave days to 60 percent of that nursing facility's total payment rate for the involved resident, and shall allow this payment only when the occupancy of the nursing facility, inclusive of bed hold days, is equal to or greater than 90 percent;

(3) two designated critical access nursing facilities, with up to 100 beds in active service, may jointly apply to the commissioner of health for a waiver of Minnesota Rules, part 4658.0500, subpart 2, in order to jointly employ a director of nursing. The commissioner of health shall consider each waiver request independently based on the criteria under Minnesota Rules, part 4658.0040;

(4) the minimum threshold under section 256B.431, subdivision 15, paragraph (e), shall be 40 percent of the amount that would otherwise apply; and

(5) the quality-based rate limits under section 256R.23, subdivisions 5 to 7, apply to designated critical access nursing facilities.

(d) Designation of a critical access nursing facility is for a period of two years, after which the benefits allowed under paragraph (c) shall be removed. Designated facilities may apply for continued designation.

(e) This section is suspended and no state or federal funding shall be appropriated or allocated for the purposes of this section from January 1, 2016, ~~to December 31, 2019.~~ through December 31, 2023.

Sec. 24. Minnesota Statutes 2018, section 256R.50, subdivision 6, is amended to read:

Subd. 6. **Determination of rate adjustment.** (a) If the amount determined in subdivision 5 is less than or equal to the amount determined in subdivision 4, the commissioner shall allow a total payment rate equal to the amount used in subdivision 5, clause (3).

(b) If the amount determined in subdivision 5 is greater than the amount determined in subdivision 4, the commissioner shall allow a rate with a case mix index of 1.0 that when used in subdivision 5, clause (3), results in the amount determined in subdivision 5 being equal to the amount determined in subdivision 4.

(c) If the commissioner relies upon provider estimates in subdivision 5, clause (1) or (2), then annually, for three years after the rates determined in this section take effect, the commissioner shall determine the accuracy of the alternative factors of medical assistance case load and the facility average case mix index used in this section and shall reduce the total payment rate if the factors used result in medical assistance costs exceeding the amount

in subdivision 4. If the actual medical assistance costs exceed the estimates by more than five percent, the commissioner shall also recover the difference between the estimated costs in subdivision 5 and the actual costs according to section 256B.0641. The commissioner may require submission of data from the receiving facility needed to implement this paragraph.

(d) When beds approved for relocation are put into active service at the destination facility, rates determined in this section must be adjusted by any adjustment amounts that were implemented after the date of the letter of approval.

(e) Rate adjustments determined under this subdivision expire after three full rate years following the effective date of the rate adjustment. This subdivision expires when the final rate adjustment determined under this subdivision expires.

Sec. 25. **DIRECTION TO COMMISSIONER; MORATORIUM EXCEPTION FUNDING.**

In fiscal year 2019, the commissioner of human services may approve moratorium exception projects under Minnesota Statutes, section 144A.073, for which the full annualized state share of medical assistance costs does not exceed $1,500,000 plus any carryover of previous appropriations for this purpose.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 26. **REPEALER.**

(a) Minnesota Statutes 2018, sections 144A.071, subdivision 4d; 256R.40; and 256R.41, are repealed effective July 1, 2019.

(b) Minnesota Statutes 2018, sections 256B.431, subdivisions 3a, 3f, 3g, 3i, 13, 15, 17, 17a, 17c, 17d, 17e, 18, 21, 22, 30, and 45; 256B.434, subdivisions 4, 4f, 4i, and 4j; and 256R.36, and Minnesota Rules, parts 9549.0057; and 9549.0060, subparts 4, 5, 6, 7, 10, 11, and 14, are repealed effective January 1, 2020.

ARTICLE 5
DISABILITY SERVICES

Section 1. Minnesota Statutes 2018, section 237.50, subdivision 4a, is amended to read:

Subd. 4a. **Deaf.** "Deaf" means a hearing loss of such severity that the ~~individual~~ person must depend primarily upon visual communication such as writing, lip reading, sign language, and gestures.

EFFECTIVE DATE. This section is effective July 1, 2019, and must be implemented by October 1, 2019.

Sec. 2. Minnesota Statutes 2018, section 237.50, is amended by adding a subdivision to read:

Subd. 4c. **Discounted telecommunications services.** "Discounted telecommunications services" means private, nonprofit, and public programs intended to subsidize or reduce the monthly costs of telecommunications services for a person who meets a program's eligibility requirements.

EFFECTIVE DATE. This section is effective July 1, 2019, and must be implemented by October 1, 2019.

Sec. 3. Minnesota Statutes 2018, section 237.50, subdivision 6a, is amended to read:

Subd. 6a. **Hard-of-hearing.** "Hard-of-hearing" means a hearing loss resulting in a functional limitation, but not to the extent that the ~~individual~~ person must depend primarily upon visual communication in all interactions.

EFFECTIVE DATE. This section is effective July 1, 2019, and must be implemented by October 1, 2019.

Sec. 4. Minnesota Statutes 2018, section 237.50, is amended by adding a subdivision to read:

Subd. 6b. **Interconnectivity product.** "Interconnectivity product" means any product including an accessory, application, or device that a person with a communication disability needs to use in conjunction with a telecommunications device to have functionally equivalent access to telecommunications services as a person without a communication disability. Interconnectivity product may include a hearing aid streamer, Bluetooth-enabled device, advanced communications application for a smartphone, or any other product the commissioner of human services deems appropriate.

EFFECTIVE DATE. This section is effective July 1, 2019, and must be implemented by October 1, 2019.

Sec. 5. Minnesota Statutes 2018, section 237.50, is amended by adding a subdivision to read:

Subd. 6c. **Multifunctional safety device.** "Multifunctional safety device" means an alerting device that has two or more functions. Multifunctional safety device may include a telephone ring signaler that also alerts a person with a communication disability to the doorbell, smoke alarm, carbon monoxide alarm, noises in another room, or other environmental sounds.

EFFECTIVE DATE. This section is effective July 1, 2019, and must be implemented by October 1, 2019.

Sec. 6. Minnesota Statutes 2018, section 237.50, subdivision 10a, is amended to read:

Subd. 10a. **Telecommunications device.** "Telecommunications device" means a device that (1) allows a person with a communication disability to have access to telecommunications services as defined in subdivision 13, and (2) is specifically selected by the Department of Human Services for its capacity to allow persons with communication disabilities to use telecommunications services in a manner that is functionally equivalent to the ability of ~~an individual~~ a person who does not have a communication disability. A telecommunications device may include a ring signaler, an amplified telephone, a hands-free telephone, a text telephone, a captioned telephone, a wireless device, a device that produces Braille output for use with a telephone, and any other device the Department of Human Services deems appropriate.

EFFECTIVE DATE. This section is effective July 1, 2019, and must be implemented by October 1, 2019.

Sec. 7. Minnesota Statutes 2018, section 237.50, subdivision 11, is amended to read:

Subd. 11. **Telecommunications Relay Services.** "Telecommunications Relay Services" or "TRS" means the telecommunications transmission services required under Federal Communications Commission regulations at Code of Federal Regulations, title 47, sections 64.604 to 64.606. TRS allows ~~an individual~~ a person who has a communication disability to use telecommunications services in a manner that is functionally equivalent to the ability of ~~an individual~~ a person who does not have a communication disability.

EFFECTIVE DATE. This section is effective July 1, 2019, and must be implemented by October 1, 2019.

Sec. 8. Minnesota Statutes 2018, section 237.51, subdivision 1, is amended to read:

Subdivision 1. **Creation.** (a) The commissioner of commerce shall:

(1) administer through interagency agreement with the commissioner of human services a program to distribute telecommunications devices, interconnectivity products, and multifunctional safety devices to eligible persons who have communication disabilities; and

(2) contract with one or more qualified vendors that serve persons who have communication disabilities to provide telecommunications relay services.

(b) For purposes of sections 237.51 to 237.56, the Department of Commerce and any organization with which it contracts pursuant to this section or section 237.54, subdivision 2, are not telephone companies or telecommunications carriers as defined in section 237.01.

EFFECTIVE DATE. This section is effective July 1, 2019, and must be implemented by October 1, 2019.

Sec. 9. Minnesota Statutes 2018, section 237.51, subdivision 5a, is amended to read:

Subd. 5a. **Commissioner of human services duties.** (a) In addition to any duties specified elsewhere in sections 237.51 to 237.56, the commissioner of human services shall:

(1) define economic hardship, special needs, and household criteria so as to determine the priority of eligible applicants for initial distribution of devices and products and to determine circumstances necessitating provision of more than one telecommunications device per household;

(2) establish a method to verify eligibility requirements;

(3) establish specifications for telecommunications devices, interconnectivity products, and multifunctional safety devices to be provided under section 237.53, subdivision 3;

(4) inform the public and specifically persons who have communication disabilities of the program; ~~and~~

(5) provide devices and products based on the assessed need of eligible applicants~~.~~; and

(6) assist a person with completing an application for discounted telecommunications services.

(b) The commissioner may establish an advisory board to advise the department in carrying out the duties specified in this section and to advise the commissioner of commerce

in carrying out duties under section 237.54. If so established, the advisory board must include, at a minimum, the following persons:

(1) at least one member who is deaf;

(2) at least one member who has a speech disability;

(3) at least one member who has a physical disability that makes it difficult or impossible for the person to access telecommunications services; and

(4) at least one member who is hard-of-hearing.

(c) The membership terms, compensation, and removal of members and the filling of membership vacancies are governed by section 15.059. Advisory board meetings shall be held at the discretion of the commissioner.

EFFECTIVE DATE. This section is effective July 1, 2019, and must be implemented by October 1, 2019.

Sec. 10. Minnesota Statutes 2018, section 237.52, subdivision 5, is amended to read:

Subd. 5. **Expenditures.** (a) Money in the fund may only be used for:

(1) expenses of the Department of Commerce, including personnel cost, public relations, advisory board members' expenses, preparation of reports, and other reasonable expenses not to exceed ten percent of total program expenditures;

(2) reimbursing the commissioner of human services for purchases made or services provided pursuant to section 237.53; and

(3) contracting for the provision of TRS required by section 237.54.

(b) All costs directly associated with the establishment of the program, the purchase and distribution of telecommunications devices, interconnectivity products, and multifunctional safety devices and the provision of TRS are either reimbursable or directly payable from the fund after authorization by the commissioner of commerce. The commissioner of commerce shall contract with one or more TRS providers to indemnify the telecommunications service providers for any fines imposed by the Federal Communications Commission related to the failure of the relay service to comply with federal service standards. Notwithstanding section 16A.41, the commissioner may advance money to the TRS providers if the providers establish to the commissioner's satisfaction that the advance payment is necessary for the provision of the service. The advance payment may be used only for working capital reserve for the operation of the service. The advance payment must

be offset or repaid by the end of the contract fiscal year together with interest accrued from the date of payment.

EFFECTIVE DATE. This section is effective July 1, 2019, and must be implemented by October 1, 2019.

Sec. 11. Minnesota Statutes 2018, section 237.53, is amended to read:

237.53 TELECOMMUNICATIONS DEVICE, INTERCONNECTIVITY PRODUCTS, AND MULTIFUNCTIONAL SAFETY DEVICES.

Subdivision 1. **Application.** A person applying for a telecommunications device, interconnectivity product, or multifunctional safety device under this section must apply to the program administrator on a form prescribed by the Department of Human Services.

Subd. 2. **Eligibility.** To be eligible to obtain a telecommunications device, interconnectivity product, or multifunctional safety device under this section, a person must:

(1) be able to benefit from and use the equipment for its intended purpose;

(2) have a communication disability;

(3) be a resident of the state;

(4) be a resident in a household that has a median income at or below the applicable median household income in the state, except a person who is deafblind applying for a Braille device may reside in a household that has a median income no more than 150 percent of the applicable median household income in the state; and

(5) be a resident in a household that has telecommunications service or that has made application for service and has been assigned a telephone number; or a resident in a residential care facility, such as a nursing home or group home where telecommunications service is not included as part of overall service provision.

Subd. 2a. **Assessment of needs.** After a person is determined to be eligible for the program, the commissioner of human services shall assess the person's telecommunications needs to determine: (1) the type of telecommunications devices that provide the person with functionally equivalent access to telecommunications services; (2) appropriate interconnectivity products for the person; and (3) multifunctional safety devices to alert the person to noises in the person's home.

Subd. 3. **Distribution.** The commissioner of human services shall (1) purchase ~~and distribute~~ a sufficient number of telecommunications devices, interconnectivity products, and multifunctional safety devices so that each eligible household receives appropriate

devices and products as determined under section 237.51, subdivision 5a~~. The commissioner of human services shall~~, and (2) distribute the devices and products to eligible households free of charge.

Subd. 4. **Training; information; maintenance.** The commissioner of human services shall maintain the telecommunications devices, interconnectivity products, and multifunctional safety devices until the warranty period expires, and provide training, without charge, to first-time users of the devices~~.~~ and products. The commissioner shall provide information about assistive communications devices and products that may benefit a program participant and about where a person may obtain or purchase assistive communications devices and products. Assistive communications devices and products include a pocket talker for a person who is hard-of-hearing, a communication board for a person with a speech disability, a one-to-one video communication application for a person who is deaf, and other devices and products designed to facilitate effective communication for a person with a communication disability.

Subd. 6. **Ownership.** Telecommunications devices, interconnectivity products, and multifunctional safety devices purchased pursuant to subdivision 3, clause (1), are the property of the state of Minnesota. Policies and procedures for the return of distributed devices ~~from individuals who withdraw from the program or whose eligibility status changes~~ and products shall be determined by the commissioner of human services.

Subd. 7. **Standards.** The telecommunications devices distributed under this section must comply with the electronic industries alliance standards and be approved by the Federal Communications Commission. The commissioner of human services must provide each eligible person a choice of several models of devices, the retail value of which may not exceed $600 for a text telephone, and a retail value of $7,000 for a Braille device, or an amount authorized by the Department of Human Services for all other telecommunications devices ~~and~~, auxiliary equipment, interconnectivity products, and multifunctional safety devices it deems cost-effective and appropriate to distribute according to sections 237.51 to 237.56.

Subd. 9. **Discounted telecommunications services assistance.** The commissioner of human services shall assist a person who is applying for telecommunication devices and products in applying for discounted telecommunications services.

EFFECTIVE DATE. This section is effective July 1, 2019, and must be implemented by October 1, 2019.

Sec. 12. Minnesota Statutes 2018, section 245C.03, is amended by adding a subdivision to read:

Subd. 13. **Early intensive developmental and behavioral intervention providers.** The commissioner shall conduct background studies according to this chapter when initiated by an early intensive developmental and behavioral intervention provider under section 256B.0949.

Sec. 13. Minnesota Statutes 2018, section 245C.10, is amended by adding a subdivision to read:

Subd. 14. **Early intensive developmental and behavioral intervention providers.** The commissioner shall recover the cost of background studies required under section 245C.03, subdivision 13, for the purposes of early intensive developmental and behavioral intervention under section 256B.0949, through a fee of no more than $32 per study charged to the enrolled agency. Fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 14. Minnesota Statutes 2018, section 245D.03, subdivision 1, is amended to read:

Subdivision 1. **Applicability.** (a) The commissioner shall regulate the provision of home and community-based services to persons with disabilities and persons age 65 and older pursuant to this chapter. The licensing standards in this chapter govern the provision of basic support services and intensive support services.

(b) Basic support services provide the level of assistance, supervision, and care that is necessary to ensure the health and welfare of the person and do not include services that are specifically directed toward the training, treatment, habilitation, or rehabilitation of the person. Basic support services include:

(1) in-home and out-of-home respite care services as defined in section 245A.02, subdivision 15, and under the brain injury, community alternative care, community access for disability inclusion, developmental disability, and elderly waiver plans, excluding out-of-home respite care provided to children in a family child foster care home licensed under Minnesota Rules, parts 2960.3000 to 2960.3100, when the child foster care license holder complies with the requirements under section 245D.06, subdivisions 5, 6, 7, and 8, or successor provisions; and section 245D.061 or successor provisions, which must be stipulated in the statement of intended use required under Minnesota Rules, part 2960.3000, subpart 4;

(2) adult companion services as defined under the brain injury, community access for disability inclusion, and elderly waiver plans, excluding adult companion services provided under the Corporation for National and Community Services Senior Companion Program established under the Domestic Volunteer Service Act of 1973, Public Law 98-288;

(3) personal support as defined under the developmental disability waiver plan;

(4) 24-hour emergency assistance, personal emergency response as defined under the community access for disability inclusion and developmental disability waiver plans;

(5) night supervision services as defined under the brain injury waiver plan;

(6) homemaker services as defined under the community access for disability inclusion, brain injury, community alternative care, developmental disability, and elderly waiver plans, excluding providers licensed by the Department of Health under chapter 144A and those providers providing cleaning services only; ~~and~~

(7) individual community living support under section 256B.0915, subdivision 3j~~.~~; and

(8) individualized home supports services as defined under the brain injury, community alternative care, and community access for disability inclusion, and developmental disability waiver plans.

(c) Intensive support services provide assistance, supervision, and care that is necessary to ensure the health and welfare of the person and services specifically directed toward the training, habilitation, or rehabilitation of the person. Intensive support services include:

(1) intervention services, including:

(i) behavioral support services as defined under the brain injury and community access for disability inclusion waiver plans;

(ii) in-home or out-of-home crisis respite services as defined under the developmental disability waiver plan; and

(iii) specialist services as defined under the current developmental disability waiver plan;

(2) in-home support services, including:

(i) in-home family support and supported living services as defined under the developmental disability waiver plan;

(ii) independent living services training as defined under the brain injury and community access for disability inclusion waiver plans;

(iii) semi-independent living services; ~~and~~

~~(iv) individualized home supports services as defined under the brain injury, community alternative care, and community access for disability inclusion waiver plans;~~

(iv) individualized home support with training services as defined under the brain injury, community alternative care, community access for disability inclusion, and developmental disability waiver plans; and

(v) individualized home support with family training services as defined under the brain injury, community alternative care, community access for disability inclusion, and developmental disability waiver plans;

(3) residential supports and services, including:

(i) supported living services as defined under the developmental disability waiver plan provided in a family or corporate child foster care residence, a family adult foster care residence, a community residential setting, or a supervised living facility;

(ii) foster care services as defined in the brain injury, community alternative care, and community access for disability inclusion waiver plans provided in a family or corporate child foster care residence, a family adult foster care residence, or a community residential setting; ~~and~~

(iii) community residential services as defined under the brain injury, community alternative care, community access for disability inclusion, and developmental disability waiver plans provided in a corporate child foster care residence, a community residential setting, or a supervised living facility;

(iv) family residential services as defined in the brain injury, community alternative care, community access for disability inclusion, and developmental disability waiver plans provided in a family child foster care residence or a family adult foster care residence; and

(v) residential services provided to more than four persons with developmental disabilities in a supervised living facility, including ICFs/DD;

(4) day services, including:

(i) structured day services as defined under the brain injury waiver plan;

(ii) day services under sections 252.41 to 252.46, and as defined under the brain injury, community alternative care, community access for disability inclusion, and developmental disability waiver plans;

(iii) day training and habilitation services under sections 252.41 to 252.46, and as defined under the developmental disability waiver plan; and

~~(iii)~~ (iv) prevocational services as defined under the brain injury ~~and~~, community alternative care, community access for disability inclusion, and developmental disability waiver plans; and

(5) employment exploration services as defined under the brain injury, community alternative care, community access for disability inclusion, and developmental disability waiver plans;

(6) employment development services as defined under the brain injury, community alternative care, community access for disability inclusion, and developmental disability waiver plans; ~~and~~

(7) employment support services as defined under the brain injury, community alternative care, community access for disability inclusion, and developmental disability waiver plans~~.~~; and

(8) integrated community support as defined under the brain injury and community access for disability inclusion waiver plans beginning January 1, 2021, and community alternative care and developmental disability waiver plans beginning January 1, 2023.

EFFECTIVE DATE. This section is effective January 1, 2021, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 15. Minnesota Statutes 2018, section 245D.071, subdivision 1, is amended to read:

Subdivision 1. **Requirements for intensive support services.** Except for services identified in section 245D.03, subdivision 1, paragraph (c), clauses (1) and (2), item (ii), a license holder providing intensive support services identified in section 245D.03, subdivision 1, paragraph (c), must comply with the requirements in this section and section 245D.07, subdivisions 1, 1a, and 3. Services identified in section 245D.03, subdivision 1, paragraph (c), clauses (1) and (2), item (ii), must comply with the requirements in section 245D.07, subdivision 2.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 16. **[245D.12] INTEGRATED COMMUNITY SUPPORTS; SETTING CAPACITY REPORT.**

(a) The license holder providing integrated community support, as defined in section 245D.03, subdivision 1, paragraph (c), clause (8), must submit a setting capacity report to the commissioner to ensure the identified location of service delivery meets the criteria of the home and community-based service requirements as specified in section 256B.492.

(b) The license holder shall provide the setting capacity report on the forms and in the manner prescribed by the commissioner. The report must include:

(1) the address of the multifamily housing building where the license holder delivers integrated community supports and owns, leases, or has a direct or indirect financial relationship with the property owner;

(2) the total number of living units in the multifamily housing building described in clause (1) where integrated community supports are delivered;

(3) the total number of living units in the multifamily housing building described in clause (1), including the living units identified in clause (2); and

(4) the percentage of living units that are controlled by the license holder in the multifamily housing building by dividing clause (2) by clause (3).

(c) Only one license holder may deliver integrated community supports at the address of the multifamily housing building.

EFFECTIVE DATE. This section is effective upon the date of federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 17. Minnesota Statutes 2018, section 252.275, subdivision 3, is amended to read:

Subd. 3. **Reimbursement.** Counties shall be reimbursed for all expenditures made pursuant to subdivision 1 at a rate of ~~70~~ 85 percent, up to the allocation determined pursuant to subdivisions 4 and 4b. However, the commissioner shall not reimburse costs of services for any person if the costs exceed the state share of the average medical assistance costs for services provided by intermediate care facilities for a person with a developmental disability for the same fiscal year, and shall not reimburse costs of a onetime living allowance for any person if the costs exceed $1,500 in a state fiscal year. The commissioner may make payments to each county in quarterly installments. The commissioner may certify an advance

of up to 25 percent of the allocation. Subsequent payments shall be made on a reimbursement basis for reported expenditures and may be adjusted for anticipated spending patterns.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 18. Minnesota Statutes 2018, section 252.41, subdivision 3, is amended to read:

Subd. 3. **Day ~~training and habilitation~~ services for adults with ~~developmental~~ disabilities.** (a) "Day ~~training and habilitation~~ services for adults with ~~developmental~~ disabilities" means services that:

(1) include supervision, training, assistance, support, ~~center-based~~ facility-based work-related activities, or other community-integrated activities designed and implemented in accordance with the ~~individual service and individual habilitation plans~~ coordinated service and support plan and coordinated service and support plan addendum required under sections 245D.02, subdivision 4, paragraphs (a) and (b), and 256B.092, subdivision 1b, and Minnesota Rules, ~~parts~~ part 9525.0004, ~~to 9525.0036~~ subpart 12, to help an adult reach and maintain the highest possible level of independence, productivity, and integration into the community; ~~and~~

(2) include day support services, prevocational services, day training and habilitation services, structured day services, and adult day services as defined in Minnesota's federally approved disability waiver plans; and

(3) are provided by a vendor licensed under sections 245A.01 to 245A.16 ~~and~~, 245D.27 to 245D.31, 252.28, subdivision 2, and 252.41 to 252.46, and Minnesota Rules, parts 9525.1200 to 9525.1330, to provide day ~~training and habilitation~~ services.

(b) Day ~~training and habilitation~~ services reimbursable under this section do not include special education and related services as defined in the Education of the Individuals with Disabilities Act, United States Code, title 20, chapter 33, section 1401, clauses (6) and (17), or vocational services funded under section 110 of the Rehabilitation Act of 1973, United States Code, title 29, section 720, as amended.

(c) Day ~~training and habilitation~~ services do not include employment exploration, employment development, or employment support services as defined in the home and community-based services waivers for people with disabilities authorized under sections 256B.092 and 256B.49.

EFFECTIVE DATE. This section is effective January 1, 2021, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 19. Minnesota Statutes 2018, section 252.41, subdivision 4, is amended to read:

Subd. 4. **Independence.** "Independence" means the extent to which persons with ~~developmental~~ disabilities exert control and choice over their own lives.

EFFECTIVE DATE. This section is effective January 1, 2021.

Sec. 20. Minnesota Statutes 2018, section 252.41, subdivision 5, is amended to read:

Subd. 5. **Integration.** "Integration" means that persons with ~~developmental~~ disabilities:

(1) use the same community resources that are used by and available to individuals who are not disabled;

(2) participate in the same community activities in which nondisabled individuals participate; and

(3) regularly interact and have contact with nondisabled individuals.

EFFECTIVE DATE. This section is effective January 1, 2021.

Sec. 21. Minnesota Statutes 2018, section 252.41, subdivision 6, is amended to read:

Subd. 6. **Productivity.** "Productivity" means that persons with ~~developmental~~ disabilities:

(1) engage in income-producing work designed to improve their income level, employment status, or job advancement; or

(2) engage in activities that contribute to a business, household, or community.

EFFECTIVE DATE. This section is effective January 1, 2021.

Sec. 22. Minnesota Statutes 2018, section 252.41, subdivision 7, is amended to read:

Subd. 7. **Regional center.** "Regional center" means any state-operated facility under the direct administrative authority of the commissioner that serves persons with ~~developmental~~ disabilities.

EFFECTIVE DATE. This section is effective January 1, 2021.

Sec. 23. Minnesota Statutes 2018, section 252.41, subdivision 9, is amended to read:

Subd. 9. **Vendor.** "Vendor" means a ~~nonprofit~~ legal entity that:

(1) is licensed under sections 245A.01 to 245A.16 ~~and~~, 245D.27 to 245D.31, 252.28, subdivision 2, and 252.41 to 252.46, and Minnesota Rules, parts 9525.1200 to 9525.1330,

to provide day ~~training and habilitation~~ services to adults with ~~developmental~~ disabilities; and

(2) does not have a financial interest in the legal entity that provides residential services to the same person or persons to whom it provides day ~~training and habilitation~~ services. This clause does not apply to regional treatment centers, state-operated, community-based programs operating according to section 252.50 until July 1, 2000, or vendors licensed prior to April 15, 1983.

EFFECTIVE DATE. This section is effective January 1, 2021.

Sec. 24. Minnesota Statutes 2018, section 252.42, is amended to read:

252.42 SERVICE PRINCIPLES.

The design and delivery of services eligible for reimbursement should reflect the following principles:

(1) services must suit a person's chronological age and be provided in the least restrictive environment possible, consistent with the needs identified in the person's ~~individual service and individual habilitation plans under~~ coordinated service and support plan and coordinated service and support plan addendum required under sections 256B.092, subdivision 1b, and 245D.02, subdivision 4, paragraphs (a) and (b), and Minnesota Rules, parts 9525.0004 ~~to 9525.0036~~, subpart 12;

(2) a person with a ~~developmental~~ disability whose individual ~~service and individual habilitation plans~~ coordinated service and support plans and coordinated service and support plan addendums authorize employment or employment-related activities shall be given the opportunity to participate in employment and employment-related activities in which nondisabled persons participate;

(3) a person with a ~~developmental~~ disability participating in work shall be paid wages commensurate with the rate for comparable work and productivity except as regional centers are governed by section 246.151;

(4) a person with a ~~developmental~~ disability shall receive services which include services offered in settings used by the general public and designed to increase the person's active participation in ordinary community activities;

(5) a person with a ~~developmental~~ disability shall participate in the patterns, conditions, and rhythms of everyday living and working that are consistent with the norms of the mainstream of society.

EFFECTIVE DATE. This section is effective January 1, 2021.

Sec. 25. Minnesota Statutes 2018, section 252.43, is amended to read:

252.43 COMMISSIONER'S DUTIES.

The commissioner shall supervise ~~county boards'~~ lead agencies' provision of day ~~training and habilitation~~ services to adults with ~~developmental~~ disabilities. The commissioner shall:

(1) determine the need for day ~~training and habilitation~~ services under section ~~252.28~~ 256B.4914;

(2) establish payment rates as provided under section 256B.4914;

(3) add transportation costs to the day services payment rate;

(4) adopt rules for the administration and provision of day ~~training and habilitation~~ services under ~~sections 252.41 to 252.46 and~~ sections 245A.01 to 245A.16 ~~and~~, 252.28, subdivision 2, and 252.41 to 252.46, and Minnesota Rules, parts 9525.1200 to 9525.1330;

~~(4)~~ (5) enter into interagency agreements necessary to ensure effective coordination and provision of day ~~training and habilitation~~ services;

~~(5)~~ (6) monitor and evaluate the costs and effectiveness of day ~~training and habilitation~~ services; and

~~(6)~~ (7) provide information and technical help to ~~county boards~~ lead agencies and vendors in their administration and provision of day ~~training and habilitation~~ services.

EFFECTIVE DATE. This section is effective January 1, 2021.

Sec. 26. Minnesota Statutes 2018, section 252.44, is amended to read:

252.44 ~~COUNTY~~ LEAD AGENCY BOARD RESPONSIBILITIES.

When the need for day ~~training and habilitation~~ services in a county or tribe has been determined under section 252.28, the board of commissioners for that ~~county~~ lead agency shall:

(1) authorize the delivery of services according to the ~~individual service and habilitation plans~~ coordinated service and support plans and coordinated service and support plan addendums required as part of the ~~county's~~ lead agency's provision of case management services under sections 256B.0913, subdivision 8; 256B.0915, subdivision 6; 256B.092, subdivision 1b; and 256B.49, subdivision 15, and Minnesota Rules, parts 9525.0004 to 9525.0036~~. For calendar years for which section 252.46, subdivisions 2 to 10, apply, the~~

~~county board shall not authorize a change in service days from the number of days authorized for the previous calendar year unless there is documentation for the change in the individual service plan. An increase in service days must also be supported by documentation that the goals and objectives assigned to the vendor cannot be met more economically and effectively by other available community services and that without the additional days of service the individual service plan could not be implemented in a manner consistent with the service principles in section 252.42~~;

(2) ensure that transportation is provided or arranged by the vendor in the most efficient and reasonable way possible; and

(3) monitor and evaluate the cost and effectiveness of the services.

EFFECTIVE DATE. This section is effective January 1, 2021.

Sec. 27. Minnesota Statutes 2018, section 252.45, is amended to read:

252.45 VENDOR'S DUTIES.

A day service vendor enrolled with the commissioner is responsible for items under clauses (1), (2), and (3), and extends only to the provision of services that are reimbursable under state and federal law. A vendor providing day ~~training and habilitation~~ services shall:

(1) provide the amount and type of services authorized in the individual service plan under coordinated service and support plan and coordinated service and support plan addendum required under sections 245D.02, subdivision 4, paragraphs (a) and (b), and 256B.092, subdivision 1b, and Minnesota Rules, ~~parts~~ part 9525.0004 ~~to 9525.0036~~, subpart 12;

(2) design the services to achieve the outcomes assigned to the vendor in the ~~individual service plan~~ coordinated service and support plan and coordinated service and support plan addendum required under sections 245D.02, subdivision 4, paragraphs (a) and (b), and 256B.092, subdivision 1b, and Minnesota Rules, part 9525.0004, subpart 12;

(3) provide or arrange for transportation of persons receiving services to and from service sites;

(4) enter into agreements with community-based intermediate care facilities for persons with developmental disabilities to ensure compliance with applicable federal regulations; and

(5) comply with state and federal law.

EFFECTIVE DATE. This section is effective January 1, 2021.

Sec. 28. Minnesota Statutes 2018, section 256.9365, is amended to read:

256.9365 PURCHASE OF ~~CONTINUATION~~ HEALTH CARE COVERAGE FOR ~~AIDS PATIENTS~~ PEOPLE LIVING WITH HIV.

Subdivision 1. **Program established.** The commissioner of human services shall establish a program to pay ~~private~~ the cost of health plan premiums and cost sharing for prescriptions, including co-payments, deductibles, and coinsurance for persons who have contracted human immunodeficiency virus (HIV) to enable them to continue coverage under or enroll in a group or individual health plan. If a person is determined to be eligible under subdivision 2, the commissioner shall pay the ~~portion of the group plan premium for which the individual is responsible, if the individual is responsible for at least 50 percent of the cost of the premium, or pay the individual plan premium~~ health insurance premiums and prescription cost sharing, including co-payments and deductibles required under section 256B.0631. The commissioner shall not pay for that portion of a premium that is attributable to other family members or dependents or is paid by the individual's employer.

Subd. 2. **Eligibility requirements.** To be eligible for the program, an applicant must ~~satisfy the following requirements:~~ meet all eligibility requirements for and enroll in Part B of the Ryan White HIV/AIDS Treatment Extension Act of 2009, Public Law 111-87.

~~(1) the applicant must provide a physician's, advanced practice registered nurse's, or physician assistant's statement verifying that the applicant is infected with HIV and is, or within three months is likely to become, too ill to work in the applicant's current employment because of HIV-related disease;~~

~~(2) the applicant's monthly gross family income must not exceed 300 percent of the federal poverty guidelines, after deducting medical expenses and insurance premiums;~~

~~(3) the applicant must not own assets with a combined value of more than $25,000; and~~

~~(4) if applying for payment of group plan premiums, the applicant must be covered by an employer's or former employer's group insurance plan.~~

Subd. 3. **Cost-effective coverage.** Requirements for the payment of individual plan premiums under subdivision 2~~, clause (5),~~ must be designed to ensure that the state cost of paying an individual plan premium does not exceed the estimated state cost that would otherwise be incurred in the medical assistance program. The commissioner shall purchase the most cost-effective coverage available for eligible individuals.

Sec. 29. Minnesota Statutes 2018, section 256B.0915, subdivision 3a, is amended to read:

Subd. 3a. **Elderly waiver cost limits.** (a) Effective on the first day of the state fiscal year in which the resident assessment system as described in section 256R.17 for nursing home rate determination is implemented and the first day of each subsequent state fiscal year, the monthly limit for the cost of waivered services to an individual elderly waiver client shall be the monthly limit of the case mix resident class to which the waiver client would be assigned under Minnesota Rules, parts 9549.0051 to 9549.0059, in effect on the last day of the previous state fiscal year, adjusted by any legislatively adopted home and community-based services percentage rate adjustment. If a legislatively authorized increase is service-specific, the monthly cost limit shall be adjusted based on the overall average increase to the elderly waiver program.

(b) The monthly limit for the cost of waivered services under paragraph (a) to an individual elderly waiver client assigned to a case mix classification A with:

(1) no dependencies in activities of daily living; or

(2) up to two dependencies in bathing, dressing, grooming, walking, and eating when the dependency score in eating is three or greater as determined by an assessment performed under section 256B.0911 shall be $1,750 per month effective on July 1, 2011, for all new participants enrolled in the program on or after July 1, 2011. This monthly limit shall be applied to all other participants who meet this criteria at reassessment. This monthly limit shall be increased annually as described in paragraphs (a) and (e).

(c) If extended medical supplies and equipment or environmental modifications are or will be purchased for an elderly waiver client, the costs may be prorated for up to 12 consecutive months beginning with the month of purchase. If the monthly cost of a recipient's waivered services exceeds the monthly limit established in paragraph (a), (b), (d), or (e), the annual cost of all waivered services shall be determined. In this event, the annual cost of all waivered services shall not exceed 12 times the monthly limit of waivered services as described in paragraph (a), (b), (d), or (e).

(d) Effective July 1, 2013, the monthly cost limit of waiver services, including any necessary home care services described in section 256B.0651, subdivision 2, for individuals who meet the criteria as ventilator-dependent given in section 256B.0651, subdivision 1, paragraph (g), shall be the average of the monthly medical assistance amount established for home care services as described in section 256B.0652, subdivision 7, and the annual average contracted amount established by the commissioner for nursing facility services

for ventilator-dependent individuals. This monthly limit shall be increased annually as described in paragraphs (a) and (e).

(e) Effective January 1, 2018, and each January 1 thereafter, the monthly cost limits for elderly waiver services in effect on the previous December 31 shall be increased by the difference between any legislatively adopted home and community-based provider rate increases effective on January 1 or since the previous January 1 and the average statewide percentage increase in nursing facility operating payment rates under chapter 256R, effective the previous January 1. This paragraph shall only apply if the average statewide percentage increase in nursing facility operating payment rates is greater than any legislatively adopted home and community-based provider rate increases effective on January 1, or occurring since the previous January 1.

(f) The commissioner shall approve an exception to the monthly case mix budget cap in paragraph (a) to pay for an enhanced rate for personal care services as described in section 256B.0659. The exception shall not exceed 107.5 percent of the budget otherwise available to the individual. The exception must be reapproved on an annual basis at the time of a participant's annual reassessment.

EFFECTIVE DATE. This section is effective July 1, 2019, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 30. Minnesota Statutes 2018, section 256B.0949, is amended by adding a subdivision to read:

Subd. 16a. **Background studies.** The requirements for background studies under this section shall be met by an early intensive developmental and behavioral intervention services agency through the commissioner's NETStudy system as provided under sections 245C.03, subdivision 13, and 245C.10, subdivision 14.

Sec. 31. Minnesota Statutes 2018, section 256B.4914, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) For purposes of this section, the following terms have the meanings given them, unless the context clearly indicates otherwise.

(b) "Commissioner" means the commissioner of human services.

(c) "Component value" means underlying factors that are part of the cost of providing services that are built into the waiver rates methodology to calculate service rates.

(d) "Customized living tool" means a methodology for setting service rates that delineates and documents the amount of each component service included in a recipient's customized living service plan.

(e) "Direct care staff" means employees providing direct services to an individual receiving services under this section. Direct care staff excludes executive, managerial, or administrative staff.

~~(e)~~ (f) "Disability waiver rates system" means a statewide system that establishes rates that are based on uniform processes and captures the individualized nature of waiver services and recipient needs.

~~(f)~~ (g) "Individual staffing" means the time spent as a one-to-one interaction specific to an individual recipient by staff to provide direct support and assistance with activities of daily living, instrumental activities of daily living, and training to participants, and is based on the requirements in each individual's coordinated service and support plan under section 245D.02, subdivision 4b; any coordinated service and support plan addendum under section 245D.02, subdivision 4c; and an assessment tool. Provider observation of an individual's needs must also be considered.

~~(g)~~ (h) "Lead agency" means a county, partnership of counties, or tribal agency charged with administering waivered services under sections 256B.092 and 256B.49.

~~(h)~~ (i) "Median" means the amount that divides distribution into two equal groups, one-half above the median and one-half below the median.

~~(i)~~ (j) "Payment or rate" means reimbursement to an eligible provider for services provided to a qualified individual based on an approved service authorization.

~~(j)~~ (k) "Rates management system" means a web-based software application that uses a framework and component values, as determined by the commissioner, to establish service rates.

~~(k)~~ (l) "Recipient" means a person receiving home and community-based services funded under any of the disability waivers.

~~(l)~~ (m) "Shared staffing" means time spent by employees, not defined under paragraph (f), providing or available to provide more than one individual with direct support and assistance with activities of daily living as defined under section 256B.0659, subdivision 1, paragraph (b); instrumental activities of daily living as defined under section 256B.0659, subdivision 1, paragraph (i); ancillary activities needed to support individual services; and training to participants, and is based on the requirements in each individual's coordinated

service and support plan under section 245D.02, subdivision 4b; any coordinated service and support plan addendum under section 245D.02, subdivision 4c; an assessment tool; and provider observation of an individual's service need. Total shared staffing hours are divided proportionally by the number of individuals who receive the shared service provisions.

~~(m)~~ (n) "Staffing ratio" means the number of recipients a service provider employee supports during a unit of service based on a uniform assessment tool, provider observation, case history, and the recipient's services of choice, and not based on the staffing ratios under section 245D.31.

~~(n)~~ (o) "Unit of service" means the following:

(1) for residential support services under subdivision 6, a unit of service is a day. Any portion of any calendar day, within allowable Medicaid rules, where an individual spends time in a residential setting is billable as a day;

(2) for day services under subdivision 7:

(i) for day training and habilitation services, a unit of service is either:

(A) a day unit of service is defined as six or more hours of time spent providing direct services and transportation; or

(B) a partial day unit of service is defined as fewer than six hours of time spent providing direct services and transportation; and

(C) for new day service recipients after January 1, 2014, 15 minute units of service must be used for fewer than six hours of time spent providing direct services and transportation;

(ii) for adult day and structured day services, a unit of service is a day or 15 minutes. A day unit of service is six or more hours of time spent providing direct services;

(iii) for day support services, a unit of service is 15 minutes; and

(iv) for prevocational services, a unit of service is a day or an hour. A day unit of service is six or more hours of time spent providing direct service;

(3) for unit-based services with programming under subdivision 8:

(i) for supported living services, a unit of service is a day or 15 minutes. When a day rate is authorized, any portion of a calendar day where an individual receives services is billable as a day; and

(ii) for all other services, a unit of service is 15 minutes; and

(4) for unit-based services without programming under subdivision 9, a unit of service is 15 minutes.

Sec. 32. Minnesota Statutes 2018, section 256B.4914, subdivision 3, is amended to read:

Subd. 3. **Applicable services.** Applicable services are those authorized under the state's home and community-based services waivers under sections 256B.092 and 256B.49, including the following, as defined in the federally approved home and community-based services plan:

(1) 24-hour customized living;

(2) adult day ~~care~~ services;

(3) adult day ~~care~~ services bath;

~~(4) behavioral programming;~~

~~(5)~~ (4) companion services;

(5) community residential services;

(6) customized living;

(7) day support services;

(8) day training and habilitation;

(9) employment exploration services;

(10) employment development services;

(11) employment support services;

(12) family residential services;

~~(8)~~ (13) housing access coordination;

~~(9)~~ (14) independent living skills;

(15) individualized home supports;

(16) individualized home supports with training;

(17) individualized home supports with family training;

~~(10)~~ (18) in-home family support;

(19) integrated community supports;

~~(11)~~ (20) night supervision;

~~(12)~~ (21) personal support;

(22) positive support services;

~~(13)~~ (23) prevocational services;

~~(14) residential care services;~~

~~(15)~~ (24) residential support services;

~~(16)~~ (25) respite services;

~~(17)~~ (26) structured day services;

~~(18) supported employment services;~~

~~(19)~~ (27) supported living services;

~~(20)~~ (28) transportation services; and

~~(21) individualized home supports;~~

~~(22) independent living skills specialist services;~~

~~(23) employment exploration services;~~

~~(24) employment development services;~~

~~(25) employment support services; and~~

~~(26)~~ (29) other services as approved by the federal government in the state home and community-based services plan.

EFFECTIVE DATE. This section is effective January 1, 2021, or upon federal approval, whichever is later, except the amendment striking clause (18) related to supported employment services is effective September 1, 2019. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 33. Minnesota Statutes 2018, section 256B.4914, subdivision 5, is amended to read:

Subd. 5. **Base wage index and standard component values.** (a) The base wage index is established to determine staffing costs associated with providing services to individuals receiving home and community-based services. For purposes of developing and calculating the proposed base wage, Minnesota-specific wages taken from job descriptions and standard occupational classification (SOC) codes from the Bureau of Labor Statistics as defined in the most recent edition of the Occupational Handbook must be used. The base wage index must be calculated as follows:

(1) for residential direct care staff, the sum of:

(i) 15 percent of the subtotal of 50 percent of the median wage for personal and home health aide (SOC code 39-9021); 30 percent of the median wage for nursing assistant (SOC code 31-1014); and 20 percent of the median wage for social and human services aide (SOC code 21-1093); and

(ii) 85 percent of the subtotal of 20 percent of the median wage for home health aide (SOC code 31-1011); 20 percent of the median wage for personal and home health aide (SOC code 39-9021); 20 percent of the median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

(2) for adult day services, 70 percent of the median wage for nursing assistant (SOC code 31-1014); and 30 percent of the median wage for personal care aide (SOC code 39-9021);

(3) for day services, day support services, and prevocational services, 20 percent of the median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

~~(3)~~ (4) for residential asleep-overnight staff, the wage is the minimum wage in Minnesota for large employers, except in a family foster care setting, the wage is 36 percent of the minimum wage in Minnesota for large employers;

~~(4)~~ (5) for ~~behavior program~~ positive supports analyst staff, 100 percent of the median wage for mental health counselors (SOC code 21-1014);

~~(5)~~ (6) for ~~behavior program~~ positive supports professional staff, 100 percent of the median wage for clinical counseling and school psychologist (SOC code 19-3031);

~~(6)~~ (7) for ~~behavior program~~ positive supports specialist staff, 100 percent of the median wage for psychiatric technicians (SOC code 29-2053);

~~(7)~~ (8) for supportive living services staff, 20 percent of the median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

~~(8)~~ (9) for housing access coordination staff, 100 percent of the median wage for community and social services specialist (SOC code 21-1099);

~~(9)~~ (10) for in-home family support and individualized home supports with family training staff, 20 percent of the median wage for nursing aide (SOC code 31-1012); 30 percent of the median wage for community social service specialist (SOC code 21-1099); 40 percent of the median wage for social and human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC code 29-2053);

~~(10)~~ (11) for individualized home supports with training services staff, 40 percent of the median wage for community social service specialist (SOC code 21-1099); 50 percent of the median wage for social and human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC code 29-2053);

~~(11)~~ (12) for independent living skills staff, 40 percent of the median wage for community social service specialist (SOC code 21-1099); 50 percent of the median wage for social and human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC code 29-2053);

~~(12) for independent living skills specialist staff, 100 percent of mental health and substance abuse social worker (SOC code 21-1023);~~

~~(13) for supported employment staff, 20 percent of the median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);~~

~~(14)~~ (13) for employment support services staff, 50 percent of the median wage for rehabilitation counselor (SOC code 21-1015); and 50 percent of the median wage for community and social services specialist (SOC code 21-1099);

~~(15)~~ (14) for employment exploration services staff, 50 percent of the median wage for rehabilitation counselor (SOC code 21-1015); and 50 percent of the median wage for community and social services specialist (SOC code 21-1099);

~~(16)~~ (15) for employment development services staff, 50 percent of the median wage for education, guidance, school, and vocational counselors (SOC code 21-1012); and 50 percent of the median wage for community and social services specialist (SOC code 21-1099);

~~(17)~~ (16) for adult companion staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant (SOC code 31-1014);

(17) for individualized home supports staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant (SOC code 31-1014);

(18) for night supervision staff, 20 percent of the median wage for home health aide (SOC code 31-1011); 20 percent of the median wage for personal and home health aide (SOC code 39-9021); 20 percent of the median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

(19) for respite staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant (SOC code 31-1014);

(20) for personal support staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant (SOC code 31-1014);

(21) for supervisory staff, 100 percent of the median wage for community and social services specialist (SOC code 21-1099), with the exception of the supervisor of ~~behavior~~ positive supports professional, ~~behavior~~ positive supports analyst, and ~~behavior~~ positive supports specialists, which is 100 percent of the median wage for clinical counseling and school psychologist (SOC code 19-3031);

(22) for registered nurse staff, 100 percent of the median wage for registered nurses (SOC code 29-1141); and

(23) for licensed practical nurse staff, 100 percent of the median wage for licensed practical nurses (SOC code 29-2061).

(b) The commissioner shall adjust the base wage index in paragraph (k) with a competitive workforce factor of 4.7 percent to provide increased compensation to direct care staff. A provider shall use the additional revenue from the competitive workforce factor to increase wages for direct care staff or to improve benefits provided to direct care staff as defined in subdivision 2, paragraph (e).

(c) Beginning February 1, 2021, and every two years thereafter, the commissioner shall report to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health and human services policy and finance an analysis of the competitive workforce factor. The report shall include recommendations to improve the competitive workforce factor using (1) the most recently available wage data by SOC code

of the weighted average wage for direct-care staff for residential services and direct-care staff for day services; (2) the most recently available wage data by SOC code of the weighted average wage of comparable occupations; and (3) labor market data as required under subdivision 10a, paragraph (g). The commissioner shall not recommend an increase or decrease of the competitive workforce factor from the current value by more than two percentage points. If, after a biennial analysis for the next report, the competitive workforce factor is less than or equal to zero, the commissioner shall recommend a competitive workforce factor of zero.

~~(b)~~ (d) Component values for ~~residential~~ corporate foster care services, corporate supportive living services daily, community residential services, and integrated community support services are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) general administrative support ratio: 13.25 percent;

(5) program-related expense ratio: 1.3 percent; and

(6) absence and utilization factor ratio: 3.9 percent.

~~(c)~~ (e) Component values for family foster care are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) general administrative support ratio: 3.3 percent;

(5) program-related expense ratio: 1.3 percent; and

(6) absence factor: 1.7 percent.

~~(d)~~ (f) Component values for day training and habilitation, day support services, and prevocational services ~~for all services~~ are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) program plan support ratio: 5.6 percent;

(5) client programming and support ratio: ten percent;

(6) general administrative support ratio: 13.25 percent;

(7) program-related expense ratio: 1.8 percent; and

(8) absence and utilization factor ratio: ~~9.4~~ 4.5 percent.

(g) Component values for adult day services:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) program plan support ratio: 5.6 percent;

(5) client programming and support ratio: 7.4 percent;

(6) general administrative support ratio: 13.25 percent;

(7) program-related expense ratio: 1.8 percent; and

(8) absence and utilization factor ratio: 4.5 percent.

~~(e)~~ (h) Component values for unit-based services with programming are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) program plan supports ratio: 15.5 percent;

(5) client programming and supports ratio: 4.7 percent;

(6) general administrative support ratio: 13.25 percent;

(7) program-related expense ratio: 6.1 percent; and

(8) absence and utilization factor ratio: 3.9 percent.

~~(f)~~ (i) Component values for unit-based services without programming except respite are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) program plan support ratio: 7.0 percent;

(5) client programming and support ratio: 2.3 percent;

(6) general administrative support ratio: 13.25 percent;

(7) program-related expense ratio: 2.9 percent; and

(8) absence and utilization factor ratio: 3.9 percent.

~~(g)~~ (j) Component values for unit-based services without programming for respite are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) general administrative support ratio: 13.25 percent;

(5) program-related expense ratio: 2.9 percent; and

(6) absence and utilization factor ratio: 3.9 percent.

~~(h) On July 1, 2017, the commissioner shall update the base wage index in paragraph (a) based on the wage data by standard occupational code (SOC) from the Bureau of Labor Statistics available on December 31, 2016. The commissioner shall publish these updated values and load them into the rate management system.~~ (k) On July 1, 2022, and every ~~five~~ two years thereafter, the commissioner shall update the base wage index in paragraph (a) based on ~~the most recently available~~ wage data by SOC from the Bureau of Labor Statistics available 18 months and one day prior. The commissioner shall publish these updated values and load them into the rate management system.

~~(i) On July 1, 2017, the commissioner shall update the framework components in paragraph (d), clause (5); paragraph (e), clause (5); and paragraph (f), clause (5); subdivision 6, clauses (8) and (9); and subdivision 7, clauses (10), (16), and (17), for changes in the Consumer Price Index. The commissioner will adjust these values higher or lower by the percentage change in the Consumer Price Index-All Items, United States city average (CPI-U) from January 1, 2014, to January 1, 2017. The commissioner shall publish these updated values and load them into the rate management system.~~ (l) On July 1, 2022, and every ~~five~~ two years thereafter, the commissioner shall update the framework components in paragraph ~~(d)~~ (f), clause (5); paragraph ~~(e)~~ (h), clause (5); ~~and~~ paragraph ~~(f)~~ (i), clause (5); paragraph (g), clause (5); subdivision 6, paragraphs (b), clauses (8) and (9)~~;~~, and (d), clause (9); and subdivision 7, clauses (10), (16), and (17), for changes in the Consumer Price Index. The commissioner shall adjust these values higher or lower by the percentage

change in the CPI-U from the date of the previous update to the ~~date of the~~ data ~~most recently~~ available on December 31 two years prior to the scheduled update. The commissioner shall publish these updated values and load them into the rate management system.

(m) Upon the implementation of automatic inflation adjustments under paragraphs (k) and (l), rate adjustments authorized under section 256B.439, subdivision 7; Laws 2013, chapter 108, article 7, section 60; and Laws 2014, chapter 312, article 27, section 75, shall be removed from service rates calculated under this section.

(n) Any rate adjustments applied to the service rates calculated under this section outside of the cost components and rate methodology specified in this section shall be removed from rate calculations upon implementation of automatic inflation adjustments under paragraphs (k) and (l).

~~(j)~~ (o) In this subdivision, if Bureau of Labor Statistics occupational codes or Consumer Price Index items are unavailable in the future, the commissioner shall recommend to the legislature codes or items to update and replace missing component values.

(p) In this subdivision, if the Bureau of Labor Statistics occupational codes used to calculate the base wage index in paragraph (a) are revised, the commissioner shall use the most recently available data prior to the scheduled update.

EFFECTIVE DATE. This section is effective January 1, 2021, or upon federal approval, whichever is later, except the new paragraph (b) is effective January 1, 2020, or upon federal approval, whichever is later; and the amendment striking paragraph (a), clause (13), related to supported employment staff, is effective September 1, 2019. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 34. Minnesota Statutes 2018, section 256B.4914, subdivision 6, is amended to read:

Subd. 6. **Payments for residential support services.** (a) For purposes of this subdivision, residential support services include 24-hour customized living services, community residential services, customized living services, family residential services, foster care services, integrated community supports, and supportive living services daily.

(b) Payments for residential support services~~, as defined in sections 256B.092, subdivision 11, and 256B.49, subdivision 22,~~ in which the person providing services does not live in the setting where the service is provided, including community residential services, corporate foster care services, and corporate supportive living services daily must be calculated as follows:

(1) determine the number of shared staffing and individual direct staff hours to meet a recipient's needs provided on site or through monitoring technology;

(2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5. This is defined as the direct-care rate;

(3) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (2). This is defined as the customized direct-care rate;

(4) multiply the number of shared and individual direct staff hours provided on site or through monitoring technology and nursing hours by the appropriate staff wages in subdivision 5, paragraph (a), or the customized direct-care rate;

(5) multiply the number of shared and individual direct staff hours provided on site or through monitoring technology and nursing hours by the product of the supervision span of control ratio in subdivision 5, paragraph (b), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause (21);

(6) combine the results of clauses (4) and (5), excluding any shared and individual direct staff hours provided through monitoring technology, and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (b), clause (2). This is defined as the direct staffing cost;

(7) for employee-related expenses, multiply the direct staffing cost, excluding any shared and individual direct staff hours provided through monitoring technology, by one plus the employee-related cost ratio in subdivision 5, paragraph (b), clause (3);

(8) for client programming and supports, the commissioner shall add $2,179; and

(9) for transportation, if provided, the commissioner shall add $1,680, or $3,000 if customized for adapted transport, based on the resident with the highest assessed need.

~~(b)~~ (c) The total rate must be calculated using the following steps:

(1) subtotal paragraph (a), clauses (7) to (9), and the direct staffing cost of any shared and individual direct staff hours provided through monitoring technology that was excluded in clause (7);

(2) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization ratio;

(3) divide the result of clause (1) by one minus the result of clause (2). This is the total payment amount; and

(4) adjust the result of clause (3) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

~~(c)~~ (d) Payments for integrated community support services must be calculated as follows:

(1) the base shared staffing shall be eight hours divided by the number of people receiving support in the integrated community support setting;

(2) the individual staffing hours shall be the average number of direct support hours provided directly to the service recipient;

(3) the personnel hourly wage rate must be based on the most recent Bureau of Labor Statistics Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5. This is defined as the direct-care rate;

(4) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (2). This is defined as the customized direct-care rate;

(5) multiply the number of shared and individual direct staff hours in clauses (1) and (2) by the appropriate staff wages in subdivision 5, paragraph (a), or the customized direct-care rate;

(6) multiply the number of shared and individual direct staff hours in clauses (1) and (2) by the product of the supervision span of control ratio in subdivision 5, paragraph (b), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause (21);

(7) combine the results of clauses (4) and (5) and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (b), clause (2). This is defined as the direct staffing cost;

(8) for employee-related expenses, multiply the direct staffing cost by one plus the employee-related cost ratio in subdivision 5, paragraph (b), clause (3); and

(9) for client programming and supports, the commissioner shall add $2,260.21 divided by 365.

(e) The total rate must be calculated using the following steps:

(1) subtotal of paragraph (d), clauses (6) to (8);

(2) sum of the standard general and administrative rate, the program-related expense ratio, and the absence and utilization ratio;

(3) divide the result of clause (1) by one minus the result of clause (2). This is the total payment amount; and

(4) adjust the result of clause (3) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

(f) The payment methodology for customized living~~,~~ and 24-hour customized living~~, and residential care~~ services must be the customized living tool. Revisions to the customized living tool must be made to reflect the services and activities unique to disability-related recipient needs and adjusted by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

~~(d) For individuals enrolled prior to January 1, 2014, the days of service authorized must meet or exceed the days of service used to convert service agreements in effect on December 1, 2013, and must not result in a reduction in spending or service utilization due to conversion during the implementation period under section 256B.4913, subdivision 4a. If during the implementation period, an individual's historical rate, including adjustments required under section 256B.4913, subdivision 4a, paragraph (c), is equal to or greater than the rate determined in this subdivision, the number of days authorized for the individual is 365.~~

~~(e)~~ (g) The number of days authorized for all individuals enrolling after January 1, 2014, in residential services must include every day that services start and end.

EFFECTIVE DATE. This section is effective January 1, 2021, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 35. Minnesota Statutes 2018, section 256B.4914, subdivision 7, is amended to read:

Subd. 7. **Payments for day programs.** Payments for services with day programs including adult day ~~care~~ services, day treatment and habilitation, day support services, prevocational services, and structured day services must be calculated as follows:

(1) determine the number of units of service and staffing ratio to meet a recipient's needs:

(i) the staffing ratios for the units of service provided to a recipient in a typical week must be averaged to determine an individual's staffing ratio; and

(ii) the commissioner, in consultation with service providers, shall develop a uniform staffing ratio worksheet to be used to determine staffing ratios under this subdivision;

(2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5;

(3) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (2). This is defined as the customized direct-care rate;

(4) multiply the number of day program direct staff hours and nursing hours by the appropriate staff wage in subdivision 5, paragraph (a), or the customized direct-care rate;

(5) multiply the number of day direct staff hours by the product of the supervision span of control ratio in subdivision 5, paragraph (d), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause (21);

(6) combine the results of clauses (4) and (5), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (d), clause (2). This is defined as the direct staffing rate;

(7) for program plan support, multiply the result of clause (6) by one plus the program plan support ratio in subdivision 5, paragraph (d), clause (4);

(8) for employee-related expenses, multiply the result of clause (7) by one plus the employee-related cost ratio in subdivision 5, paragraph (d), clause (3);

(9) for client programming and supports, multiply the result of clause (8) by one plus the client programming and support ratio in subdivision 5, paragraph (d), clause (5);

(10) for program facility costs, add $19.30 per week with consideration of staffing ratios to meet individual needs;

(11) for adult day bath services, add $7.01 per 15 minute unit;

(12) this is the subtotal rate;

(13) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(14) divide the result of clause (12) by one minus the result of clause (13). This is the total payment amount;

(15) adjust the result of clause (14) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services;

(16) for transportation provided as part of day training and habilitation for an individual who does not require a lift, add:

(i) $10.50 for a trip between zero and ten miles for a nonshared ride in a vehicle without a lift, $8.83 for a shared ride in a vehicle without a lift, and $9.25 for a shared ride in a vehicle with a lift;

(ii) $15.75 for a trip between 11 and 20 miles for a nonshared ride in a vehicle without a lift, $10.58 for a shared ride in a vehicle without a lift, and $11.88 for a shared ride in a vehicle with a lift;

(iii) $25.75 for a trip between 21 and 50 miles for a nonshared ride in a vehicle without a lift, $13.92 for a shared ride in a vehicle without a lift, and $16.88 for a shared ride in a vehicle with a lift; or

(iv) $33.50 for a trip of 51 miles or more for a nonshared ride in a vehicle without a lift, $16.50 for a shared ride in a vehicle without a lift, and $20.75 for a shared ride in a vehicle with a lift;

(17) for transportation provided as part of day training and habilitation for an individual who does require a lift, add:

(i) $19.05 for a trip between zero and ten miles for a nonshared ride in a vehicle with a lift, and $15.05 for a shared ride in a vehicle with a lift;

(ii) $32.16 for a trip between 11 and 20 miles for a nonshared ride in a vehicle with a lift, and $28.16 for a shared ride in a vehicle with a lift;

(iii) $58.76 for a trip between 21 and 50 miles for a nonshared ride in a vehicle with a lift, and $58.76 for a shared ride in a vehicle with a lift; or

(iv) $80.93 for a trip of 51 miles or more for a nonshared ride in a vehicle with a lift, and $80.93 for a shared ride in a vehicle with a lift.

EFFECTIVE DATE. This section is effective January 1, 2021, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 36. Minnesota Statutes 2018, section 256B.4914, subdivision 8, is amended to read:

Subd. 8. **Payments for unit-based services with programming.** Payments for unit-based services with programming, including ~~behavior programming~~ employment exploration services, employment development services, housing access coordination, individualized home supports with family training, individualized home supports with training, in-home

family support, independent living skills training, ~~independent living skills specialist services, individualized home supports,~~ and hourly supported living services~~, employment exploration services, employment development services, supported employment, and employment support services~~ provided to an individual outside of any day or residential service plan must be calculated as follows, unless the services are authorized separately under subdivision 6 or 7:

(1) determine the number of units of service to meet a recipient's needs;

(2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5;

(3) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (2). This is defined as the customized direct-care rate;

(4) multiply the number of direct staff hours by the appropriate staff wage in subdivision 5, paragraph (a), or the customized direct-care rate;

(5) multiply the number of direct staff hours by the product of the supervision span of control ratio in subdivision 5, paragraph (e), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause (21);

(6) combine the results of clauses (4) and (5), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (e), clause (2). This is defined as the direct staffing rate;

(7) for program plan support, multiply the result of clause (6) by one plus the program plan supports ratio in subdivision 5, paragraph (e), clause (4);

(8) for employee-related expenses, multiply the result of clause (7) by one plus the employee-related cost ratio in subdivision 5, paragraph (e), clause (3);

(9) for client programming and supports, multiply the result of clause (8) by one plus the client programming and supports ratio in subdivision 5, paragraph (e), clause (5);

(10) this is the subtotal rate;

(11) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(12) divide the result of clause (10) by one minus the result of clause (11). This is the total payment amount;

~~(13) for supported employment provided in a shared manner, divide the total payment amount in clause (12) by the number of service recipients, not to exceed three. For employment support services provided in a shared manner, divide the total payment amount in clause (12) by the number of service recipients, not to exceed six. For independent living skills training and individualized home supports provided in a shared manner, divide the total payment amount in clause (12) by the number of service recipients, not to exceed two; and~~

(13) for employment exploration services provided in a shared manner, divide the total payment amount in clause (12) by the number of service recipients, not to exceed five. For employment support services provided in a shared manner, divide the total payment amount in clause (12) by the number of service recipients, not to exceed six. For independent living skills training, individualized home supports with training, and individualized home supports with family training provided in a shared manner, divide the total payment amount in clause (12) by the number of service recipients, not to exceed two; and

(14) adjust the result of clause (13) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

EFFECTIVE DATE. This section is effective January 1, 2021, or upon federal approval, whichever is later, except the amendments striking "supported employment," in paragraph (a) and striking clause (13) related to supported employment are effective September 1, 2019. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 37. Minnesota Statutes 2018, section 256B.4914, subdivision 9, is amended to read:

Subd. 9. **Payments for unit-based services without programming.** Payments for unit-based services without programming, including individualized home supports, night supervision, personal support, respite, and companion care provided to an individual outside of any day or residential service plan must be calculated as follows unless the services are authorized separately under subdivision 6 or 7:

(1) for all services except respite, determine the number of units of service to meet a recipient's needs;

(2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rate or rates derived by the commissioner as provided in subdivision 5;

(3) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (2). This is defined as the customized direct care rate;

(4) multiply the number of direct staff hours by the appropriate staff wage in subdivision 5 or the customized direct care rate;

(5) multiply the number of direct staff hours by the product of the supervision span of control ratio in subdivision 5, paragraph (f), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause (21);

(6) combine the results of clauses (4) and (5), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (f), clause (2). This is defined as the direct staffing rate;

(7) for program plan support, multiply the result of clause (6) by one plus the program plan support ratio in subdivision 5, paragraph (f), clause (4);

(8) for employee-related expenses, multiply the result of clause (7) by one plus the employee-related cost ratio in subdivision 5, paragraph (f), clause (3);

(9) for client programming and supports, multiply the result of clause (8) by one plus the client programming and support ratio in subdivision 5, paragraph (f), clause (5);

(10) this is the subtotal rate;

(11) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(12) divide the result of clause (10) by one minus the result of clause (11). This is the total payment amount;

(13) for respite services, determine the number of day units of service to meet an individual's needs;

(14) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rate or rates derived by the commissioner as provided in subdivision 5;

(15) for a recipient requiring deaf and hard-of-hearing customization under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (14). This is defined as the customized direct care rate;

(16) multiply the number of direct staff hours by the appropriate staff wage in subdivision 5, paragraph (a);

(17) multiply the number of direct staff hours by the product of the supervisory span of control ratio in subdivision 5, paragraph (g), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause (21);

(18) combine the results of clauses (16) and (17), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (g), clause (2). This is defined as the direct staffing rate;

(19) for employee-related expenses, multiply the result of clause (18) by one plus the employee-related cost ratio in subdivision 5, paragraph (g), clause (3);

(20) this is the subtotal rate;

(21) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(22) divide the result of clause (20) by one minus the result of clause (21). This is the total payment amount; ~~and~~

(23) for individualized home supports provided in a shared manner, divide the total payment amount in clause (12) by the number of service recipients, not to exceed two. For respite care services provided in a shared manner, divide the total payment amount in clause (22) by the number of service recipients, not to exceed three; and

(24) adjust the result of ~~clauses (12) and (22)~~ clause (23) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

EFFECTIVE DATE. This section is effective January 1, 2021, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 38. Minnesota Statutes 2018, section 256B.4914, subdivision 10, is amended to read:

Subd. 10. **Updating payment values and additional information.** ~~(a) From January 1, 2014, through December 31, 2017, the commissioner shall develop and implement uniform procedures to refine terms and adjust values used to calculate payment rates in this section.~~

~~(b)~~ (a) No later than July 1, 2014, the commissioner shall, within available resources, begin to conduct research and gather data and information from existing state systems or other outside sources on the following items:

(1) differences in the underlying cost to provide services and care across the state; and

(2) mileage, vehicle type, lift requirements, incidents of individual and shared rides, and units of transportation for all day services, which must be collected from providers using the rate management worksheet and entered into the rates management system; and

(3) the distinct underlying costs for services provided by a license holder under sections 245D.05, 245D.06, 245D.07, 245D.071, 245D.081, and 245D.09, and for services provided by a license holder certified under section 245D.33.

~~(c) Beginning January 1, 2014, through December 31, 2018, using a statistically valid set of rates management system data, the commissioner, in consultation with stakeholders, shall analyze for each service the average difference in the rate on December 31, 2013, and the framework rate at the individual, provider, lead agency, and state levels. The commissioner shall issue semiannual reports to the stakeholders on the difference in rates by service and by county during the banding period under section 256B.4913, subdivision 4a. The commissioner shall issue the first report by October 1, 2014, and the final report shall be issued by December 31, 2018.~~

~~(d)~~ (b) No later than July 1, 2014, the commissioner, in consultation with stakeholders, shall begin the review and evaluation of the following values already in subdivisions 6 to 9, or issues that impact all services, including, but not limited to:

(1) values for transportation rates;

(2) values for services where monitoring technology replaces staff time;

(3) values for indirect services;

(4) values for nursing;

(5) values for the facility use rate in day services, and the weightings used in the day service ratios and adjustments to those weightings;

(6) values for workers' compensation as part of employee-related expenses;

(7) values for unemployment insurance as part of employee-related expenses;

(8) direct care workforce labor market measures;

(9) any changes in state or federal law with a direct impact on the underlying cost of providing home and community-based services; ~~and~~

~~(9)~~ (10) outcome measures, determined by the commissioner, for home and community-based services rates determined under this section~~.~~; and

(11) different competitive workforce factors by service, as determined under subdivision 5, paragraph (k).

~~(e)~~ (c) The commissioner shall report to the chairs and the ranking minority members of the legislative committees and divisions with jurisdiction over health and human services policy and finance with the information and data gathered under paragraphs ~~(b) to (d)~~ (a) and (b) on ~~the following dates:~~

~~(1) January 15, 2015, with preliminary results and data;~~

~~(2) January 15, 2016, with a status implementation update, and additional data and summary information;~~

~~(3) January 15, 2017, with the full report; and~~

~~(4)~~ January 15, ~~2020~~ 2021, with another full report, and a full report once every four years thereafter.

~~(f) The commissioner shall implement a regional adjustment factor to all rate calculations in subdivisions 6 to 9, effective no later than January 1, 2015.~~ (d) Beginning ~~July 1, 2017~~ January 1, 2022, the commissioner shall renew analysis and implement changes to the regional adjustment factors ~~when adjustments required under subdivision 5, paragraph (h), occur~~ once every six years. Prior to implementation, the commissioner shall consult with stakeholders on the methodology to calculate the adjustment.

~~(g)~~ (e) The commissioner shall provide a public notice via LISTSERV in October of each year beginning October 1, 2014, containing information detailing legislatively approved changes in:

(1) calculation values including derived wage rates and related employee and administrative factors;

(2) service utilization;

(3) county and tribal allocation changes; and

(4) information on adjustments made to calculation values and the timing of those adjustments.

The information in this notice must be effective January 1 of the following year.

~~(h)~~ (f) When the available shared staffing hours in a residential setting are insufficient to meet the needs of an individual who enrolled in residential services after January 1, 2014, or insufficient to meet the needs of an individual with a service agreement adjustment

described in section 256B.4913, subdivision 4a, paragraph (f), then individual staffing hours shall be used.

~~(i) The commissioner shall study the underlying cost of absence and utilization for day services. Based on the commissioner's evaluation of the data collected under this paragraph, the commissioner shall make recommendations to the legislature by January 15, 2018, for changes, if any, to the absence and utilization factor ratio component value for day services.~~

~~(j)~~ (g) Beginning July 1, 2017, the commissioner shall collect transportation and trip information for all day services through the rates management system.

(h) The commissioner shall develop a new rate methodology for residential services in which the service provider lives in the setting where the service is provided based on levels of support needs. The commissioner shall submit recommendations to the legislative committees with jurisdiction over human services of the new rate methodology to replace subdivision 6, paragraph (d), by January 1, 2020.

(i) The commissioner shall study value-based payment strategies for fee-for-service home and community-based services and submit a report to the legislative committees with jurisdiction over human services by October 1, 2020, with recommended strategies to improve the quality, efficiency, and effectiveness of services.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 39. Minnesota Statutes 2018, section 256B.4914, subdivision 10a, is amended to read:

Subd. 10a. **Reporting and analysis of cost data.** (a) The commissioner must ensure that wage values and component values in subdivisions 5 to 9 reflect the cost to provide the service. As determined by the commissioner, in consultation with stakeholders identified in section 256B.4913, subdivision 5, a provider enrolled to provide services with rates determined under this section must submit requested cost data to the commissioner to support research on the cost of providing services that have rates determined by the disability waiver rates system. Requested cost data may include, but is not limited to:

(1) worker wage costs;

(2) benefits paid;

(3) supervisor wage costs;

(4) executive wage costs;

(5) vacation, sick, and training time paid;

(6) taxes, workers' compensation, and unemployment insurance costs paid;

(7) administrative costs paid;

(8) program costs paid;

(9) transportation costs paid;

(10) vacancy rates; and

(11) other data relating to costs required to provide services requested by the commissioner.

(b) At least once in any five-year period, a provider must submit cost data for a fiscal year that ended not more than 18 months prior to the submission date. The commissioner shall provide each provider a 90-day notice prior to its submission due date. If a provider fails to submit required reporting data, the commissioner shall provide notice to providers that have not provided required data 30 days after the required submission date, and a second notice for providers who have not provided required data 60 days after the required submission date. The commissioner shall temporarily suspend payments to the provider if cost data is not received 90 days after the required submission date. Withheld payments shall be made once data is received by the commissioner.

(c) The commissioner shall conduct a random validation of data submitted under paragraph (a) to ensure data accuracy. The commissioner shall analyze cost documentation in paragraph (a) and provide recommendations for adjustments to cost components.

(d) The commissioner shall analyze cost documentation in paragraph (a) and, in consultation with stakeholders identified in section 256B.4913, subdivision 5, may submit recommendations on component values and inflationary factor adjustments to the chairs and ranking minority members of the legislative committees with jurisdiction over human services every four years beginning January 1, ~~2020~~ 2021. The commissioner shall make recommendations in conjunction with reports submitted to the legislature according to subdivision 10, paragraph ~~(e)~~ (c). The commissioner shall release cost data in an aggregate form, and cost data from individual providers shall not be released except as provided for in current law.

(e) The commissioner, in consultation with stakeholders identified in section 256B.4913, subdivision 5, shall develop and implement a process for providing training and technical assistance necessary to support provider submission of cost documentation required under paragraph (a).

(f) By December 31, 2020, providers paid with rates calculated under subdivision 5, paragraph (b), shall identify additional revenues from the competitive workforce factor and prepare a written distribution plan for the revenues. A provider shall make the provider's distribution plan available and accessible to all direct care staff for a minimum of one calendar year. Upon request, a provider shall submit the written distribution plan to the commissioner.

(g) Providers enrolled to provide services with rates determined under section 256B.4914, subdivision 3, shall submit labor market data to the commissioner annually on or before November 1, including but not limited to:

(1) number of direct care staff;

(2) wages of direct care staff;

(3) overtime wages of direct care staff;

(4) hours worked by direct care staff;

(5) overtime hours worked by direct care staff;

(6) benefits provided to direct care staff;

(7) direct care staff job vacancies; and

(8) direct care staff retention rates.

(h) The commissioner shall publish annual reports on provider and state-level labor market data, including but not limited to the data obtained under paragraph (g).

(i) The commissioner shall temporarily suspend payments to the provider if data requested under paragraph (g) is not received 90 days after the required submission date. Withheld payments shall be made once data is received by the commissioner.

EFFECTIVE DATE. This section is effective the day following final enactment except paragraph (g) is effective November 1, 2019, and paragraph (h) is effective February 1, 2020.

Sec. 40. Minnesota Statutes 2018, section 256B.85, subdivision 3, is amended to read:

Subd. 3. **Eligibility.** (a) CFSS is available to a person who meets one of the following:

(1) is an enrollee of medical assistance as determined under section 256B.055, 256B.056, or 256B.057, subdivisions 5 and 9;

(2) is a participant in the alternative care program under section 256B.0913;

(3) is a waiver participant as defined under section 256B.0915, 256B.092, 256B.093, or 256B.49; or

(4) has medical services identified in a person's individualized education program and is eligible for services as determined in section 256B.0625, subdivision 26.

(b) In addition to meeting the eligibility criteria in paragraph (a), a person must also meet all of the following:

(1) require assistance and be determined dependent in one activity of daily living or Level I behavior based on assessment under section 256B.0911; and

(2) is not a participant under a family support grant under section 252.32.

(c) A pregnant woman eligible for medical assistance under section 256B.055, subdivision 6, is eligible for CFSS without federal financial participation if the woman: (1) is eligible for CFSS under paragraphs (a) and (b); and (2) does not meet institutional level of care, as determined under section 256B.0911.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 41. Laws 2017, First Special Session chapter 6, article 3, section 49, is amended to read:

Sec. 49. **ELECTRONIC ~~SERVICE DELIVERY DOCUMENTATION SYSTEM~~ VISIT VERIFICATION.**

Subdivision 1. **Documentation; establishment.** The commissioner of human services shall establish implementation requirements and standards for ~~an~~ electronic ~~service delivery documentation system~~ visit verification to comply with the 21st Century Cures Act, Public Law 114-255. Within available appropriations, the commissioner shall take steps to comply with the electronic visit verification requirements in the 21st Century Cures Act, Public Law 114-255.

Subd. 2. **Definitions.** (a) For purposes of this section, the terms in this subdivision have the meanings given them.

(b) "Electronic ~~service delivery documentation~~ visit verification" means the electronic documentation of the:

(1) type of service performed;

(2) individual receiving the service;

(3) date of the service;

(4) location of the service delivery;

(5) individual providing the service; and

(6) time the service begins and ends.

(c) "Electronic ~~service delivery documentation~~ visit verification system" means a system that provides electronic ~~service delivery documentation~~ verification of services that complies with the 21st Century Cures Act, Public Law 114-255, and the requirements of subdivision 3.

(d) "Service" means one of the following:

(1) personal care assistance services as defined in Minnesota Statutes, section 256B.0625, subdivision 19a, and provided according to Minnesota Statutes, section 256B.0659; ~~or~~

(2) community first services and supports under Minnesota Statutes, section 256B.85;

(3) home health services under Minnesota Statutes, section 256B.0625, subdivision 6a; or

(4) other medical supplies and equipment or home and community-based services that are required to be electronically verified by the 21st Century Cures Act, Public Law 114-255.

Subd. 3. **Requirements.** (a) In developing implementation requirements for ~~an~~ electronic ~~service delivery documentation system~~ visit verification, the commissioner shall ~~consider electronic visit verification systems and other electronic service delivery documentation methods. The commissioner shall convene stakeholders that will be impacted by an electronic service delivery system, including service providers and their representatives, service recipients and their representatives, and, as appropriate, those with expertise in the development and operation of an electronic service delivery documentation system, to~~ ensure that the requirements:

(1) are minimally administratively and financially burdensome to a provider;

(2) are minimally burdensome to the service recipient and the least disruptive to the service recipient in receiving and maintaining allowed services;

(3) consider existing best practices and use of electronic ~~service delivery documentation~~ visit verification;

(4) are conducted according to all state and federal laws;

(5) are effective methods for preventing fraud when balanced against the requirements of clauses (1) and (2); and

(6) are consistent with the Department of Human Services' policies related to covered services, flexibility of service use, and quality assurance.

(b) The commissioner shall make training available to providers on the electronic ~~service delivery documentation~~ visit verification system requirements.

(c) The commissioner shall establish baseline measurements related to preventing fraud and establish measures to determine the effect of electronic ~~service delivery documentation~~ visit verification requirements on program integrity.

(d) The commissioner shall make a state-selected electronic visit verification system available to providers of services.

Subd. 3a. **Provider requirements.** (a) A provider of services may select any electronic visit verification system that meets the requirements established by the commissioner.

(b) All electronic visit verification systems used by providers to comply with the requirements established by the commissioner must provide data to the commissioner in a format and at a frequency to be established by the commissioner.

(c) Providers must implement the electronic visit verification systems required under this section by a date established by the commissioner to be set after the state-selected electronic visit verification systems for personal care services and home health services are in production. For purposes of this paragraph, "personal care services" and "home health services" have the meanings given in United States Code, title 42, section 1396b(l)(5).

~~Subd. 4. **Legislative report.** (a) The commissioner shall submit a report by January 15, 2018, to the chairs and ranking minority members of the legislative committees with jurisdiction over human services with recommendations, based on the requirements of subdivision 3, to establish electronic service delivery documentation system requirements and standards. The report shall identify:~~

~~(1) the essential elements necessary to operationalize a base-level electronic service delivery documentation system to be implemented by January 1, 2019; and~~

~~(2) enhancements to the base-level electronic service delivery documentation system to be implemented by January 1, 2019, or after, with projected operational costs and the costs and benefits for system enhancements.~~

~~(b) The report must also identify current regulations on service providers that are either inefficient, minimally effective, or will be unnecessary with the implementation of an electronic service delivery documentation system.~~

Sec. 42. **DIRECTION TO COMMISSIONER; SKILLED NURSE VISIT RATES.**

The commissioner of human services shall ensure that skilled nurse visits reimbursed under Minnesota Statutes, section 256B.0653, are coded, specific to the category of the nurse performing the visit, using code sets compliant with the Health Insurance Portability and Accountability Act, Public Law 104-191. "Skilled nurse visit" has the meaning given in Minnesota Statutes, section 256B.0653, subdivision 2, paragraph (j).

Sec. 43. **DIRECTION TO COMMISSIONER; INTERAGENCY AGREEMENTS.**

By October 1, 2019, the Department of Commerce, Public Utilities Commission, and Department of Human Services must amend all interagency agreements necessary to implement sections 1 to 11.

Sec. 44. **DIRECTION TO COMMISSIONER; FEDERAL AUTHORITY FOR RECONFIGURED WAIVER SERVICES.**

The commissioner of human services shall seek necessary federal authority to implement new and reconfigured waiver services under section 45. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained and when new services are fully implemented.

Sec. 45. **DISABILITY WAIVER RECONFIGURATION.**

Subdivision 1. **Intent.** It is the intent of the legislature to reform the medical assistance waiver programs for people with disabilities to simplify administration of the programs, encourage person-centered supports, enhance each person's personal authority over the person's service choice, align benefits across waivers, encourage equity across programs and populations, and promote long-term sustainability of needed services.

Subd. 2. **Report.** By January 15, 2021, the commissioner of human services shall submit a report to the members of the legislative committees with jurisdiction over human services on any necessary waivers, state plan amendments, requests for new funding or realignment of existing funds, any changes to state statute or rule, and any other federal authority necessary to implement this section.

Subd. 3. **Proposal.** By January 15, 2021, the commissioner shall develop a proposal to reconfigure the medical assistance waivers provided in sections 256B.092 and 256B.49. The proposal shall include all necessary plans for implementing two home and community-based services waiver programs, as authorized under section 1915(c) of the Social Security Act that serve persons who are determined to require the levels of care provided in a nursing home, a hospital, a neurobehavioral hospital, or an intermediate care facility for persons with developmental disabilities.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 46. **INDIVIDUAL PROVIDERS OF DIRECT SUPPORT SERVICES.**

The labor agreement between the state of Minnesota and the Service Employees International Union Healthcare Minnesota, submitted to the Legislative Coordinating Commission on ....., is ratified.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 47. **RATE INCREASE FOR DIRECT SUPPORT SERVICES PROVIDERS WORKFORCE NEGOTIATIONS.**

(a) If the labor agreement between the state of Minnesota and the Service Employees International Union Healthcare Minnesota under Minnesota Statutes, section 179A.54, is approved pursuant to Minnesota Statutes, section 3.855, the commissioner of human services shall increase reimbursement rates, individual budgets, grants, or allocations by 2.37 percent for services provided on or after July 1, 2019, to implement the minimum hourly wage, holiday, enhanced rate, and paid time off provisions of that agreement.

(b) The rate changes described in this section apply to direct support services provided through a covered program, as defined in Minnesota Statutes, section 256B.0711, subdivision 1.

Sec. 48. **REPEALER.**

(a) Minnesota Statutes 2018, section 256B.0705, is repealed.

(b) Minnesota Statutes 2018, sections 252.431; and 252.451, are repealed.

(c) Minnesota Statutes 2018, section 252.41, subdivision 8, is repealed.

EFFECTIVE DATE. Paragraph (a) is effective the day following final enactment. Paragraph (b) is effective September 1, 2019. Paragraph (c) is effective January 1, 2020.

ARTICLE 6
CHEMICAL AND MENTAL HEALTH

Section 1. Minnesota Statutes 2018, section 245.4889, subdivision 1, is amended to read:

Subdivision 1. **Establishment and authority.** (a) The commissioner is authorized to make grants from available appropriations to assist:

(1) counties;

(2) Indian tribes;

(3) children's collaboratives under section 124D.23 or 245.493; or

(4) mental health service providers.

(b) The following services are eligible for grants under this section:

(1) services to children with emotional disturbances as defined in section 245.4871, subdivision 15, and their families;

(2) transition services under section 245.4875, subdivision 8, for young adults under age 21 and their families;

(3) respite care services for children with severe emotional disturbances who are at risk of out-of-home placement;

(4) children's mental health crisis services;

(5) mental health services for people from cultural and ethnic minorities;

(6) children's mental health screening and follow-up diagnostic assessment and treatment;

(7) services to promote and develop the capacity of providers to use evidence-based practices in providing children's mental health services;

(8) school-linked mental health services~~, including transportation for children receiving school-linked mental health services when school is not in session~~ under section 245.4901;

(9) building evidence-based mental health intervention capacity for children birth to age five;

(10) suicide prevention and counseling services that use text messaging statewide;

(11) mental health first aid training;

(12) training for parents, collaborative partners, and mental health providers on the impact of adverse childhood experiences and trauma and development of an interactive website to share information and strategies to promote resilience and prevent trauma;

(13) transition age services to develop or expand mental health treatment and supports for adolescents and young adults 26 years of age or younger;

(14) early childhood mental health consultation;

(15) evidence-based interventions for youth at risk of developing or experiencing a first episode of psychosis, and a public awareness campaign on the signs and symptoms of psychosis;

(16) psychiatric consultation for primary care practitioners; and

(17) providers to begin operations and meet program requirements when establishing a new children's mental health program. These may be start-up grants.

(c) Services under paragraph (b) must be designed to help each child to function and remain with the child's family in the community and delivered consistent with the child's treatment plan. Transition services to eligible young adults under this paragraph must be designed to foster independent living in the community.

(d) As a condition of receiving grant funds, a grantee shall obtain all available third-party reimbursement sources, if applicable.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 2. **[245.4901] SCHOOL-LINKED MENTAL HEALTH GRANTS.**

Subdivision 1. **Establishment.** The commissioner of human services shall establish a school-linked mental health grant program to provide early identification and intervention for students with mental health needs and to build the capacity of schools to support students with mental health needs in the classroom.

Subd. 2. **Eligible applicants.** An eligible applicant for school-linked mental health grants is an entity that is:

(1) certified under Minnesota Rules, parts 9520.0750 to 9520.0870;

(2) a community mental health center under section 256B.0625, subdivision 5;

(3) an Indian health service facility or a facility owned and operated by a tribe or tribal organization operating under United States Code, title 25, section 5321;

(4) a provider of children's therapeutic services and supports as defined in section 256B.0943; or

(5) enrolled in medical assistance as a mental health or substance use disorder provider agency and employs at least two full-time equivalent mental health professionals as defined

in section 245.4871, subdivision 27, clauses (1) to (6), or two alcohol and drug counselors licensed or exempt from licensure under chapter 148F who are qualified to provide clinical services to children and families.

Subd. 3. **Allowable grant activities and related expenses.** (a) Allowable grant activities and related expenses may include but are not limited to:

(1) identifying and diagnosing mental health conditions of students;

(2) delivering mental health treatment and services to students and their families, including via telemedicine consistent with section 256B.0625, subdivision 3b;

(3) supporting families in meeting their child's needs, including navigating health care, social service, and juvenile justice systems;

(4) providing transportation for students receiving school-linked mental health services when school is not in session;

(5) building the capacity of schools to meet the needs of students with mental health concerns, including school staff development activities for licensed and nonlicensed staff; and

(6) purchasing equipment, connection charges, on-site coordination, set-up fees, and site fees in order to deliver school-linked mental health services via telemedicine.

(b) Grantees shall obtain all available third-party reimbursement sources as a condition of receiving a grant. For purposes of this grant program, a third-party reimbursement source excludes a public school as defined in section 120A.20, subdivision 1. Grantees shall serve students regardless of health coverage status or ability to pay.

Subd. 4. **Data collection and outcome measurement.** Grantees shall provide data to the commissioner for the purpose of evaluating the effectiveness of the school-linked mental health grant program.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 3. Minnesota Statutes 2018, section 245.735, subdivision 3, is amended to read:

Subd. 3. **Certified community behavioral health clinics.** (a) The commissioner shall establish a state certification process for certified community behavioral health clinics (CCBHCs) ~~to be eligible for the prospective payment system in paragraph (f)~~. Entities that choose to be CCBHCs must:

(1) comply with the CCBHC criteria published by the United States Department of Health and Human Services;

(2) employ or contract for clinic staff who have backgrounds in diverse disciplines, including licensed mental health professionals and licensed alcohol and drug counselors, and staff who are culturally and linguistically trained to ~~serve~~ meet the needs of the ~~clinic's patient~~ population the clinic serves;

(3) ensure that clinic services are available and accessible to ~~patients~~ individuals and families of all ages and genders and that crisis management services are available 24 hours per day;

(4) establish fees for clinic services for ~~nonmedical assistance patients~~ individuals who are not enrolled in medical assistance using a sliding fee scale that ensures that services to patients are not denied or limited due to ~~a patient's~~ an individual's inability to pay for services;

(5) comply with quality assurance reporting requirements and other reporting requirements, including any required reporting of encounter data, clinical outcomes data, and quality data;

(6) provide crisis mental health and substance use services, withdrawal management services, emergency crisis intervention services, and stabilization services; screening, assessment, and diagnosis services, including risk assessments and level of care determinations; ~~patient-centered~~ person- and family-centered treatment planning; outpatient mental health and substance use services; targeted case management; psychiatric rehabilitation services; peer support and counselor services and family support services; and intensive community-based mental health services, including mental health services for members of the armed forces and veterans;

(7) provide coordination of care across settings and providers to ensure seamless transitions for ~~patients~~ individuals being served across the full spectrum of health services, including acute, chronic, and behavioral needs. Care coordination may be accomplished through partnerships or formal contracts with:

(i) counties, health plans, pharmacists, pharmacies, rural health clinics, federally qualified health centers, inpatient psychiatric facilities, substance use and detoxification facilities, or community-based mental health providers; and

(ii) other community services, supports, and providers, including schools, child welfare agencies, juvenile and criminal justice agencies, Indian health services clinics, tribally licensed health care and mental health facilities, urban Indian health clinics, Department of

Veterans Affairs medical centers, outpatient clinics, drop-in centers, acute care hospitals, and hospital outpatient clinics;

(8) be certified as mental health clinics under section 245.69, subdivision 2;

~~(9) be certified to provide integrated treatment for co-occurring mental illness and substance use disorders in adults or children under Minnesota Rules, chapter 9533, effective July 1, 2017;~~

~~(10)~~ (9) comply with standards relating to mental health services in Minnesota Rules, parts 9505.0370 to 9505.0372;

~~(11)~~ (10) be licensed to provide ~~chemical dependency~~ substance use disorder treatment under chapter 245G;

~~(12)~~ (11) be certified to provide children's therapeutic services and supports under section 256B.0943;

~~(13)~~ (12) be certified to provide adult rehabilitative mental health services under section 256B.0623;

~~(14)~~ (13) be enrolled to provide mental health crisis response services under section 256B.0624;

~~(15)~~ (14) be enrolled to provide mental health targeted case management under section 256B.0625, subdivision 20;

~~(16)~~ (15) comply with standards relating to mental health case management in Minnesota Rules, parts 9520.0900 to 9520.0926; ~~and~~

~~(17)~~ (16) provide services that comply with the evidence-based practices described in paragraph (e)~~.~~; and

(17) comply with standards relating to peer services under sections 256B.0615, 256B.0616, and 245G.07, subdivision 1, paragraph (a), clause (5), if peer services are provided.

(b) If an entity is unable to provide one or more of the services listed in paragraph (a), clauses (6) to (17), the commissioner may certify the entity as a CCBHC, if the entity has a current contract with another entity that has the required authority to provide that service and that meets federal CCBHC criteria as a designated collaborating organization, or, to the extent allowed by the federal CCBHC criteria, the commissioner may approve a referral arrangement. The CCBHC must meet federal requirements regarding the type and scope of services to be provided directly by the CCBHC.

(c) Notwithstanding any other law that requires a county contract or other form of county approval for certain services listed in paragraph (a), clause (6), a clinic that otherwise meets CCBHC requirements may receive the prospective payment under ~~paragraph (f)~~ section 256B.0625, subdivision 5m, for those services without a county contract or county approval. There is no county share when medical assistance pays the CCBHC prospective payment. As part of the certification process in paragraph (a), the commissioner shall require a letter of support from the CCBHC's host county confirming that the CCBHC and the county or counties it serves have an ongoing relationship to facilitate access and continuity of care, especially for individuals who are uninsured or who may go on and off medical assistance.

(d) When the standards listed in paragraph (a) or other applicable standards conflict or address similar issues in duplicative or incompatible ways, the commissioner may grant variances to state requirements if the variances do not conflict with federal requirements. If standards overlap, the commissioner may substitute all or a part of a licensure or certification that is substantially the same as another licensure or certification. The commissioner shall consult with stakeholders, as described in subdivision 4, before granting variances under this provision. For the CCBHC that is certified but not approved for prospective payment under section 256B.0625, subdivision 5m, the commissioner may grant a variance under this paragraph if the variance does not increase the state share of costs.

(e) The commissioner shall issue a list of required evidence-based practices to be delivered by CCBHCs, and may also provide a list of recommended evidence-based practices. The commissioner may update the list to reflect advances in outcomes research and medical services for persons living with mental illnesses or substance use disorders. The commissioner shall take into consideration the adequacy of evidence to support the efficacy of the practice, the quality of workforce available, and the current availability of the practice in the state. At least 30 days before issuing the initial list and any revisions, the commissioner shall provide stakeholders with an opportunity to comment.

~~(f) The commissioner shall establish standards and methodologies for a prospective payment system for medical assistance payments for services delivered by certified community behavioral health clinics, in accordance with guidance issued by the Centers for Medicare and Medicaid Services. During the operation of the demonstration project, payments shall comply with federal requirements for an enhanced federal medical assistance percentage. The commissioner may include quality bonus payment in the prospective payment system based on federal criteria and on a clinic's provision of the evidence-based practices in paragraph (e). The prospective payment system does not apply to MinnesotaCare.~~

~~Implementation of the prospective payment system is effective July 1, 2017, or upon federal approval, whichever is later.~~

~~(g) The commissioner shall seek federal approval to continue federal financial participation in payment for CCBHC services after the federal demonstration period ends for clinics that were certified as CCBHCs during the demonstration period and that continue to meet the CCBHC certification standards in paragraph (a). Payment for CCBHC services shall cease effective July 1, 2019, if continued federal financial participation for the payment of CCBHC services cannot be obtained.~~

~~(h) The commissioner may certify at least one CCBHC located in an urban area and at least one CCBHC located in a rural area, as defined by federal criteria. To the extent allowed by federal law, the commissioner may limit the number of certified clinics so that the projected claims for certified clinics will not exceed the funds budgeted for this purpose. The commissioner shall give preference to clinics that:~~

~~(1) provide a comprehensive range of services and evidence-based practices for all age groups, with services being fully coordinated and integrated; and~~

~~(2) enhance the state's ability to meet the federal priorities to be selected as a CCBHC demonstration state.~~

~~(i)~~ (f) The commissioner shall recertify CCBHCs at least every three years. The commissioner shall establish a process for decertification and shall require corrective action, medical assistance repayment, or decertification of a CCBHC that no longer meets the requirements in this section or that fails to meet the standards provided by the commissioner in the application and certification process.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 4. Minnesota Statutes 2018, section 254B.02, subdivision 1, is amended to read:

Subdivision 1. **Chemical dependency treatment allocation.** The chemical dependency treatment appropriation shall be placed in a special revenue account. ~~The commissioner shall annually transfer funds from the chemical dependency fund to pay for operation of the drug and alcohol abuse normative evaluation system and to pay for all costs incurred by adding two positions for licensing of chemical dependency treatment and rehabilitation programs located in hospitals for which funds are not otherwise appropriated.~~ The ~~remainder of the~~ money in the special revenue account must be used according to the requirements in this chapter.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 5. Minnesota Statutes 2018, section 254B.03, subdivision 2, is amended to read:

Subd. 2. **Chemical dependency fund payment.** (a) Payment from the chemical dependency fund is limited to payments for services other than detoxification licensed under Minnesota Rules, parts 9530.6510 to 9530.6590, that, if located outside of federally recognized tribal lands, would be required to be licensed by the commissioner as a chemical dependency treatment or rehabilitation program under sections 245A.01 to 245A.16, and services other than detoxification provided in another state that would be required to be licensed as a chemical dependency program if the program were in the state. Out of state vendors must also provide the commissioner with assurances that the program complies substantially with state licensing requirements and possesses all licenses and certifications required by the host state to provide chemical dependency treatment. Vendors receiving payments from the chemical dependency fund must not require co-payment from a recipient of benefits for services provided under this subdivision. The vendor is prohibited from using the client's public benefits to offset the cost of services paid under this section. The vendor shall not require the client to use public benefits for room or board costs. This includes but is not limited to cash assistance benefits under chapters 119B, 256D, and 256J, or SNAP benefits. Retention of SNAP benefits is a right of a client receiving services through the consolidated chemical dependency treatment fund or through state contracted managed care entities. Payment from the chemical dependency fund shall be made for necessary room and board costs provided by vendors ~~certified according to~~ meeting the criteria under section 254B.05, subdivision 1a, or in a community hospital licensed by the commissioner of health according to sections 144.50 to 144.56 to a client who is:

(1) determined to meet the criteria for placement in a residential chemical dependency treatment program according to rules adopted under section 254A.03, subdivision 3; and

(2) concurrently receiving a chemical dependency treatment service in a program licensed by the commissioner and reimbursed by the chemical dependency fund.

(b) A county may, from its own resources, provide chemical dependency services for which state payments are not made. A county may elect to use the same invoice procedures and obtain the same state payment services as are used for chemical dependency services for which state payments are made under this section if county payments are made to the state in advance of state payments to vendors. When a county uses the state system for payment, the commissioner shall make monthly billings to the county using the most recent available information to determine the anticipated services for which payments will be made in the coming month. Adjustment of any overestimate or underestimate based on actual

expenditures shall be made by the state agency by adjusting the estimate for any succeeding month.

(c) The commissioner shall coordinate chemical dependency services and determine whether there is a need for any proposed expansion of chemical dependency treatment services. The commissioner shall deny vendor certification to any provider that has not received prior approval from the commissioner for the creation of new programs or the expansion of existing program capacity. The commissioner shall consider the provider's capacity to obtain clients from outside the state based on plans, agreements, and previous utilization history, when determining the need for new treatment services.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 6. Minnesota Statutes 2018, section 254B.03, subdivision 4, is amended to read:

Subd. 4. **Division of costs.** (a) Except for services provided by a county under section 254B.09, subdivision 1, or services provided under section 256B.69, the county shall, out of local money, pay the state for 22.95 percent of the cost of chemical dependency services, ~~including~~ except for those services provided to persons ~~eligible for~~ enrolled in medical assistance under chapter 256B and room and board services under section 254B.05, subdivision 5, paragraph (b), clause (12). Counties may use the indigent hospitalization levy for treatment and hospital payments made under this section.

(b) 22.95 percent of any state collections from private or third-party pay, less 15 percent for the cost of payment and collections, must be distributed to the county that paid for a portion of the treatment under this section.

~~(c) For fiscal year 2017 only, the 22.95 percentages under paragraphs (a) and (b) are equal to 20.2 percent.~~

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 7. Minnesota Statutes 2018, section 254B.04, subdivision 1, is amended to read:

Subdivision 1. **Eligibility.** (a) Persons eligible for benefits under Code of Federal Regulations, title 25, part 20, ~~and persons eligible for medical assistance benefits under sections 256B.055, 256B.056, and 256B.057, subdivisions 1, 5, and 6, or~~ who meet the income standards of section 256B.056, subdivision 4, and are not enrolled in medical assistance, are entitled to chemical dependency fund services. State money appropriated for this paragraph must be placed in a separate account established for this purpose.

(b) Persons with dependent children who are determined to be in need of chemical dependency treatment pursuant to an assessment under section 626.556, subdivision 10, or a case plan under section 260C.201, subdivision 6, or 260C.212, shall be assisted by the local agency to access needed treatment services. Treatment services must be appropriate for the individual or family, which may include long-term care treatment or treatment in a facility that allows the dependent children to stay in the treatment facility. The county shall pay for out-of-home placement costs, if applicable.

(c) Notwithstanding paragraph (a), persons enrolled in medical assistance are eligible for room and board services under section 254B.05, subdivision 5, paragraph (b), clause (12).

EFFECTIVE DATE. This section is effective September 1, 2019.

Sec. 8. Minnesota Statutes 2018, section 254B.05, subdivision 1a, is amended to read:

Subd. 1a. **Room and board provider requirements.** (a) Effective January 1, 2000, vendors of room and board are eligible for chemical dependency fund payment if the vendor:

(1) has rules prohibiting residents bringing chemicals into the facility or using chemicals while residing in the facility and provide consequences for infractions of those rules;

(2) is determined to meet applicable health and safety requirements;

(3) is not a jail or prison;

(4) is not concurrently receiving funds under chapter 256I for the recipient;

(5) admits individuals who are 18 years of age or older;

(6) is registered as a board and lodging or lodging establishment according to section 157.17;

(7) has awake staff on site 24 hours per day;

(8) has staff who are at least 18 years of age and meet the requirements of section 245G.11, subdivision 1, paragraph (b);

(9) has emergency behavioral procedures that meet the requirements of section 245G.16;

(10) meets the requirements of section 245G.08, subdivision 5, if administering medications to clients;

(11) meets the abuse prevention requirements of section 245A.65, including a policy on fraternization and the mandatory reporting requirements of section 626.557;

(12) documents coordination with the treatment provider to ensure compliance with section 254B.03, subdivision 2;

(13) protects client funds and ensures freedom from exploitation by meeting the provisions of section 245A.04, subdivision 13;

(14) has a grievance procedure that meets the requirements of section 245G.15, subdivision 2; and

(15) has sleeping and bathroom facilities for men and women separated by a door that is locked, has an alarm, or is supervised by awake staff.

(b) Programs licensed according to Minnesota Rules, chapter 2960, are exempt from paragraph (a), clauses (5) to (15).

(c) Licensed programs providing intensive residential treatment services or residential crisis services pursuant to section 256B.0622 are eligible vendors of room and board and are exempt from paragraph (a), clauses (6) to (15).

EFFECTIVE DATE. This section is effective September 1, 2019.

Sec. 9. Minnesota Statutes 2018, section 254B.06, subdivision 1, is amended to read:

Subdivision 1. **State collections.** The commissioner is responsible for all collections from persons determined to be partially responsible for the cost of care of an eligible person receiving services under Laws 1986, chapter 394, sections 8 to 20. The commissioner may initiate, or request the attorney general to initiate, necessary civil action to recover the unpaid cost of care. The commissioner may collect all third-party payments for chemical dependency services provided under Laws 1986, chapter 394, sections 8 to 20, including private insurance and federal Medicaid and Medicare financial participation. ~~The commissioner shall deposit in a dedicated account a percentage of collections to pay for the cost of operating the chemical dependency consolidated treatment fund invoice processing and vendor payment system, billing, and collections.~~ The remaining receipts must be deposited in the chemical dependency fund.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 10. Minnesota Statutes 2018, section 254B.06, subdivision 2, is amended to read:

Subd. 2. **Allocation of collections.** ~~(a) The commissioner shall allocate all federal financial participation collections to a special revenue account.~~ The commissioner shall

allocate 77.05 percent of patient payments and third-party payments to the special revenue account and 22.95 percent to the county financially responsible for the patient.

~~(b) For fiscal year 2017 only, the commissioner's allocation to the special revenue account shall be increased from 77.05 percent to 79.8 percent and the county financial responsibility shall be reduced from 22.95 percent to 20.2 percent.~~

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 11. Minnesota Statutes 2018, section 256.478, is amended to read:

256.478 ~~HOME AND COMMUNITY-BASED SERVICES TRANSITIONS GRANTS~~ TRANSITION TO COMMUNITY INITIATIVE.

Subdivision 1. **Eligibility.** (a) An individual is eligible for the transition to community initiative if the individual meets the following criteria:

(1) without the additional resources available through the transitions to community initiative the individual would otherwise remain at the Anoka-Metro Regional Treatment Center, a state-operated community behavioral health hospital, or the Minnesota Security Hospital;

(2) the individual's discharge would be significantly delayed without the additional resources available through the transitions to community initiative; and

(3) the individual met treatment objectives and no longer needs hospital-level care or a secure treatment setting.

(b) An individual who is in a community hospital and on the waiting list for the Anoka-Metro Regional Treatment Center, but for whom alternative community placement would be appropriate is eligible for the transition to community initiative upon the commissioner's approval.

Subd. 2. **Transition grants.** The commissioner shall make available ~~home and community-based services~~ transition to community grants to ~~serve~~ assist individuals ~~who do not meet eligibility criteria for the medical assistance program under section 256B.056 or 256B.057, but who otherwise meet the criteria under section 256B.092, subdivision 13, or 256B.49, subdivision 24~~ who met the criteria under subdivision 1.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 12. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision to read:

Subd. 5m. **Certified community behavioral health clinic services.** (a) Medical assistance covers certified community behavioral health clinic (CCBHC) services that meet the requirements of section 245.735, subdivision 3.

(b) The commissioner shall establish standards and methodologies for a prospective payment system for medical assistance payments for services delivered by a CCBHC, in accordance with guidance issued by the Centers for Medicare and Medicaid Services. The commissioner may include a quality bonus payment in the prospective payment system based on federal criteria and on a CCBHC's provision of the evidence-based practices in section 245.735, subdivision 3, paragraph (e). The prospective payment system does not apply to MinnesotaCare.

(c) To the extent allowed by federal law, the commissioner may limit the number of CCBHCs for the prospective payment system in paragraph (b) to ensure that the projected claims do not exceed the money appropriated for this purpose. The commissioner shall apply the following priorities, in the order listed, to give preference to clinics that:

(1) provide a comprehensive range of services and evidence-based practices for all age groups, with services being fully coordinated and integrated;

(2) are certified as CCBHCs during the federal CCBHC demonstration period;

(3) receive CCBHC grants from the United States Department of Health and Human Services; or

(4) focus on serving individuals in tribal areas and other underserved communities.

(d) Unless otherwise indicated in applicable federal requirements, the prospective payment system must continue to be based on the federal instructions issued for the federal CCBHC demonstration, except:

(1) the commissioner shall rebase CCBHC rates at least every two years; and

(2) the prospective payment rate under this section does not apply for services rendered by CCBHCs to individuals who are dually eligible for Medicare and medical assistance when Medicare is the primary payer for the service.

EFFECTIVE DATE. Contingent upon federal approval, this section is effective July 1, 2019. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained or denied.

Sec. 13. Minnesota Statutes 2018, section 256B.0625, subdivision 24, is amended to read:

Subd. 24. **Other medical or remedial care.** Medical assistance covers any other medical or remedial care licensed and recognized under state law unless otherwise prohibited by law~~, except licensed chemical dependency treatment programs or primary treatment or extended care treatment units in hospitals that are covered under chapter 254B. The commissioner shall include chemical dependency services in the state medical assistance plan for federal reporting purposes, but payment must be made under chapter 254B~~. The commissioner shall publish in the State Register a list of elective surgeries that require a second medical opinion before medical assistance reimbursement, and the criteria and standards for deciding whether an elective surgery should require a second medical opinion. The list and criteria and standards are not subject to the requirements of sections 14.01 to 14.69.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 14. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision to read:

Subd. 24a. **Substance use disorder services.** Medical assistance covers substance use disorder treatment services according to section 254B.05, subdivision 5, except for room and board.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 15. Minnesota Statutes 2018, section 256B.0625, subdivision 45a, is amended to read:

Subd. 45a. **Psychiatric residential treatment facility services for persons younger than 21 years of age.** (a) Medical assistance covers psychiatric residential treatment facility services, according to section 256B.0941, for persons younger than 21 years of age. Individuals who reach age 21 at the time they are receiving services are eligible to continue receiving services until they no longer require services or until they reach age 22, whichever occurs first.

(b) For purposes of this subdivision, "psychiatric residential treatment facility" means a facility other than a hospital that provides psychiatric services, as described in Code of Federal Regulations, title 42, sections 441.151 to 441.182, to individuals under age 21 in an inpatient setting.

(c) The commissioner shall enroll up to ~~150~~ 300 certified psychiatric residential treatment facility services beds ~~at up to six sites~~. The commissioner shall select psychiatric residential treatment facility services providers through a request for proposals process. Providers of state-operated services may respond to the request for proposals. The commissioner shall prioritize programs that demonstrate the capacity to serve children and youth with aggressive and risky behaviors toward themselves or others, multiple diagnoses, neurodevelopmental disorders, or complex trauma related issues.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 16. Minnesota Statutes 2018, section 256B.0625, subdivision 57, is amended to read:

Subd. 57. **Payment for Part B Medicare crossover claims.** (a) Effective for services provided on or after January 1, 2012, medical assistance payment for an enrollee's cost-sharing associated with Medicare Part B is limited to an amount up to the medical assistance total allowed, when the medical assistance rate exceeds the amount paid by Medicare.

(b) Excluded from this limitation are payments for mental health services and payments for dialysis services provided to end-stage renal disease patients. The exclusion for mental health services does not apply to payments for physician services provided by psychiatrists and advanced practice nurses with a specialty in mental health.

(c) Excluded from this limitation are payments to federally qualified health centers ~~and~~, rural health clinics, and CCBHCs subject to the prospective payment system under subdivision 5m.

EFFECTIVE DATE. Contingent upon federal approval, this section is effective July 1, 2019. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained or denied.

Sec. 17. Minnesota Statutes 2018, section 256B.0915, subdivision 3b, is amended to read:

Subd. 3b. **Cost limits for elderly waiver applicants who reside in a nursing facility or another eligible facility.** (a) For a person who is a nursing facility resident at the time of requesting a determination of eligibility for elderly waivered services, a monthly conversion budget limit for the cost of elderly waivered services may be requested. The monthly conversion budget limit for the cost of elderly waiver services shall be ~~the resident class assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, for that resident in the nursing facility where the resident currently resides until July 1 of the state fiscal year~~

~~in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented. Effective on July 1 of the state fiscal year in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented, the monthly conversion budget limit for the cost of elderly waiver services shall be~~ based on the per diem nursing facility rate as determined by the resident assessment system as described in section ~~256B.438~~ 256R.17 for residents in the nursing facility where the elderly waiver applicant currently resides. The monthly conversion budget limit shall be calculated by multiplying the per diem by 365, divided by 12, and reduced by the recipient's maintenance needs allowance as described in subdivision 1d. The initially approved monthly conversion budget limit shall be adjusted annually as described in subdivision 3a, paragraph (a). The limit under this ~~subdivision~~ paragraph only applies to persons discharged from a nursing facility after a minimum 30-day stay and found eligible for waivered services on or after July 1, 1997. For conversions from the nursing home to the elderly waiver with consumer directed community support services, the nursing facility per diem used to calculate the monthly conversion budget limit must be reduced by a percentage equal to the percentage difference between the consumer directed services budget limit that would be assigned according to the federally approved waiver plan and the corresponding community case mix cap, but not to exceed 50 percent.

(b) A person who meets elderly waiver eligibility criteria and the eligibility criteria under section 256.478, subdivision 1, is eligible for a special monthly budget limit for the cost of elderly waivered services up to $21,610 per month. The special monthly budget limit must be adjusted annually as described in subdivision 3a, paragraphs (a) and (e). For a person using a special monthly budget limit under the elderly waiver with consumer-directed community support services, the special monthly budget limit must be reduced as described in paragraph (a).

(c) The commissioner may provide an additional payment for documented costs between a threshold determined by the commissioner and the special monthly budget limit to a managed care plan for elderly waiver services provided to a person who is: (1) eligible for a special monthly budget limit under paragraph (b); and (2) enrolled in a managed care plan that provides elderly waiver services under section 256B.69.

(d) For monthly conversion budget limits under paragraph (a) and special monthly budget limits under paragraph (b), the service rate limits for adult foster care under subdivision 3d and for customized living under subdivision 3e may be exceeded if necessary for the provider to meet identified needs and provide services as approved in the coordinated service and support plan, if the total cost of all services does not exceed the monthly conversion or

special monthly budget limit. Service rates must be established using tools provided by the commissioner.

(e) The following costs must be included in determining the total monthly costs for the waiver client:

(1) cost of all waivered services, including specialized supplies and equipment and environmental accessibility adaptations; and

(2) cost of skilled nursing, home health aide, and personal care services reimbursable by medical assistance.

EFFECTIVE DATE. This section is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes once federal approval is obtained.

Sec. 18. Minnesota Statutes 2018, section 256B.092, subdivision 13, is amended to read:

Subd. 13. **Waiver allocations for transition populations.** (a) The commissioner shall make available additional waiver allocations and additional necessary resources ~~to assure timely discharges from the Anoka-Metro Regional Treatment Center and the Minnesota Security Hospital in St. Peter~~ for individuals who meet the ~~following~~ eligibility criteria~~:~~ established under section 256.478, subdivision 1.

~~(1) are otherwise eligible for the developmental disabilities waiver under this section;~~

~~(2) who would otherwise remain at the Anoka-Metro Regional Treatment Center or the Minnesota Security Hospital;~~

~~(3) whose discharge would be significantly delayed without the available waiver allocation; and~~

~~(4) who have met treatment objectives and no longer meet hospital level of care.~~

(b) Additional waiver allocations under this subdivision must meet cost-effectiveness requirements of the federal approved waiver plan.

(c) Any corporate foster care home developed under this subdivision must be considered an exception under section 245A.03, subdivision 7, paragraph (a).

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 19. Minnesota Statutes 2018, section 256B.49, subdivision 24, is amended to read:

Subd. 24. **Waiver allocations for transition populations.** (a) The commissioner shall make available additional waiver allocations and additional necessary resources ~~to assure~~

~~timely discharges from the Anoka-Metro Regional Treatment Center and the Minnesota Security Hospital in St. Peter~~ for individuals who meet the ~~following~~ eligibility criteria~~:~~ established under section 256.478, subdivision 1.

~~(1) are otherwise eligible for the brain injury, community access for disability inclusion, or community alternative care waivers under this section;~~

~~(2) who would otherwise remain at the Anoka-Metro Regional Treatment Center or the Minnesota Security Hospital;~~

~~(3) whose discharge would be significantly delayed without the available waiver allocation; and~~

~~(4) who have met treatment objectives and no longer meet hospital level of care.~~

(b) Additional waiver allocations under this subdivision must meet cost-effectiveness requirements of the federal approved waiver plan.

(c) Any corporate foster care home developed under this subdivision must be considered an exception under section 245A.03, subdivision 7, paragraph (a).

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 20. Minnesota Statutes 2018, section 256I.04, subdivision 1, is amended to read:

Subdivision 1. **Individual eligibility requirements.** An individual is eligible for and entitled to a housing support payment to be made on the individual's behalf if the agency has approved the setting where the individual will receive housing support and the individual meets the requirements in paragraph (a), (b), or (c).

(a) The individual is aged, blind, or is over 18 years of age with a disability as determined under the criteria used by the title II program of the Social Security Act, and meets the resource restrictions and standards of section 256P.02, and the individual's countable income after deducting the (1) exclusions and disregards of the SSI program, (2) the medical assistance personal needs allowance under section 256B.35, and (3) an amount equal to the income actually made available to a community spouse by an elderly waiver participant under the provisions of sections 256B.0575, paragraph (a), clause (4), and 256B.058, subdivision 2, is less than the monthly rate specified in the agency's agreement with the provider of housing support in which the individual resides.

(b) The individual meets a category of eligibility under section 256D.05, subdivision 1, paragraph (a), clauses (1), (3), (4) to (8), and (13), and paragraph (b), if applicable, and the individual's resources are less than the standards specified by section 256P.02, and the

individual's countable income as determined under section 256P.06, less the medical assistance personal needs allowance under section 256B.35 is less than the monthly rate specified in the agency's agreement with the provider of housing support in which the individual resides.

(c) The individual ~~receives licensed residential crisis stabilization services under section 256B.0624, subdivision 7, and is receiving medical assistance. The individual may receive concurrent housing support payments if receiving licensed residential crisis stabilization services under section 256B.0624, subdivision 7.~~ lacks a fixed, adequate, nighttime residence upon discharge from a residential behavioral health treatment program, as determined by treatment staff from the residential behavioral health treatment program. An individual is eligible under this paragraph for up to three months, including a full or partial month from the individual's move-in date at a setting approved for housing support following discharge from treatment, plus two full months.

EFFECTIVE DATE. This section is effective September 1, 2019.

Sec. 21. Minnesota Statutes 2018, section 256I.04, subdivision 2f, is amended to read:

Subd. 2f. **Required services.** (a) In licensed and registered settings under subdivision 2a, providers shall ensure that participants have at a minimum:

(1) food preparation and service for three nutritional meals a day on site;

(2) a bed, clothing storage, linen, bedding, laundering, and laundry supplies or service;

(3) housekeeping, including cleaning and lavatory supplies or service; and

(4) maintenance and operation of the building and grounds, including heat, water, garbage removal, electricity, telephone for the site, cooling, supplies, and parts and tools to repair and maintain equipment and facilities.

(b) In addition, when providers serve participants described in subdivision 1, paragraph (c), the providers are required to assist the participants in applying for continuing housing support payments before the end of the eligibility period.

EFFECTIVE DATE. This section is effective September 1, 2019.

Sec. 22. Minnesota Statutes 2018, section 256I.06, subdivision 8, is amended to read:

Subd. 8. **Amount of housing support payment.** (a) The amount of a room and board payment to be made on behalf of an eligible individual is determined by subtracting the individual's countable income under section 256I.04, subdivision 1, for a whole calendar

month from the room and board rate for that same month. The housing support payment is determined by multiplying the housing support rate times the period of time the individual was a resident or temporarily absent under section 256I.05, subdivision 1c, paragraph (d).

(b) For an individual with earned income under paragraph (a), prospective budgeting must be used to determine the amount of the individual's payment for the following six-month period. An increase in income shall not affect an individual's eligibility or payment amount until the month following the reporting month. A decrease in income shall be effective the first day of the month after the month in which the decrease is reported.

(c) For an individual who receives ~~licensed residential crisis stabilization services under section 256B.0624, subdivision 7,~~ housing support payments under section 256I.04, subdivision 1, paragraph (c), the amount of the housing support payment is determined by multiplying the housing support rate times the period of time the individual was a resident.

EFFECTIVE DATE. This section is effective September 1, 2019.

Sec. 23. Laws 2017, First Special Session chapter 6, article 8, section 71, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective for services provided on July 1, 2017, ~~through April 30, 2019, and expires May 1, 2019~~ and thereafter.

EFFECTIVE DATE. This section is effective April 30, 2019.

Sec. 24. Laws 2017, First Special Session chapter 6, article 8, section 72, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective for services provided on July 1, 2017, ~~through April 30, 2019, and expires May 1, 2019~~ and thereafter.

EFFECTIVE DATE. This section is effective April 30, 2019.

Sec. 25. **DIRECTION TO COMMISSIONER; IMPROVING SCHOOL-LINKED MENTAL HEALTH GRANT PROGRAM.**

(a) The commissioner of human services, in collaboration with the commissioner of education, representatives from the education community, mental health providers, and advocates, shall assess the school-linked mental health grant program under Minnesota Statutes, section 245.4901, and develop recommendations for improvements. The assessment must include but is not limited to the following:

(1) promoting stability among current grantees and school partners;

(2) assessing the minimum number of full-time equivalents needed per school site to effectively carry out the program;

(3) developing a funding formula that promotes sustainability and consistency across grant cycles;

(4) reviewing current data collection and evaluation; and

(5) analyzing the impact on outcomes when a school has a school-linked mental health program, a multi-tier system of supports, and sufficient school support personnel to meet the needs of students.

(b) The commissioner shall provide a report of the findings of the assessment and recommendations, including any necessary statutory changes, to the legislative committees with jurisdiction over mental health and education by January 15, 2020.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 26. **REPEALER.**

Minnesota Statutes 2018, section 254B.03, subdivision 4a, is repealed.

ARTICLE 7
UNIFORM SERVICE STANDARDS

Section 1. Minnesota Statutes 2018, section 62A.152, subdivision 3, is amended to read:

Subd. 3. **Provider discrimination prohibited.** All group policies and group subscriber contracts that provide benefits for mental or nervous disorder treatments in a hospital must provide direct reimbursement for those services if performed by a mental health professional, as defined in sections 245.462, subdivision 18~~, clauses (1) to (5)~~; and 245.4871, subdivision 27, ~~clauses (1) to (5),~~ to the extent that the services and treatment are within the scope of mental health professional licensure.

This subdivision is intended to provide payment of benefits for mental or nervous disorder treatments performed by a licensed mental health professional in a hospital and is not intended to change or add benefits for those services provided in policies or contracts to which this subdivision applies.

Sec. 2. Minnesota Statutes 2018, section 62A.3094, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** (a) For purposes of this section, the terms defined in paragraphs (b) to (d) have the meanings given.

(b) "Autism spectrum disorders" means the conditions as determined by criteria set forth in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

(c) "Medically necessary care" means health care services appropriate, in terms of type, frequency, level, setting, and duration, to the enrollee's condition, and diagnostic testing and preventative services. Medically necessary care must be consistent with generally accepted practice parameters as determined by physicians and licensed psychologists who typically manage patients who have autism spectrum disorders.

(d) "Mental health professional" means a mental health professional as ~~defined in section 245.4871, subdivision 27~~ described in section 245I.16, subdivision 2, clause (1), (2), (3), (4), or (6), who has training and expertise in autism spectrum disorder and child development.

Sec. 3. Minnesota Statutes 2018, section 148B.5301, subdivision 2, is amended to read:

Subd. 2. **Supervision.** (a) To qualify as a LPCC, an applicant must have completed 4,000 hours of post-master's degree supervised professional practice in the delivery of clinical services in the diagnosis and treatment of mental illnesses and disorders in both children and adults. The supervised practice shall be conducted according to the requirements in paragraphs (b) to (e).

(b) The supervision must have been received under a contract that defines clinical practice and supervision from a mental health professional as defined in section 245.462, subdivision 18~~, clauses (1) to (6)~~, or 245.4871, subdivision 27, ~~clauses (1) to (6),~~ or by a board-approved supervisor, who has at least two years of postlicensure experience in the delivery of clinical services in the diagnosis and treatment of mental illnesses and disorders. All supervisors must meet the supervisor requirements in Minnesota Rules, part 2150.5010.

(c) The supervision must be obtained at the rate of two hours of supervision per 40 hours of professional practice. The supervision must be evenly distributed over the course of the supervised professional practice. At least 75 percent of the required supervision hours must be received in person. The remaining 25 percent of the required hours may be received by telephone or by audio or audiovisual electronic device. At least 50 percent of the required hours of supervision must be received on an individual basis. The remaining 50 percent may be received in a group setting.

(d) The supervised practice must include at least 1,800 hours of clinical client contact.

(e) The supervised practice must be clinical practice. Supervision includes the observation by the supervisor of the successful application of professional counseling knowledge, skills,

and values in the differential diagnosis and treatment of psychosocial function, disability, or impairment, including addictions and emotional, mental, and behavioral disorders.

Sec. 4. Minnesota Statutes 2018, section 148E.0555, subdivision 6, is amended to read:

Subd. 6. **Qualifications during grandfathering for licensure as LICSW.** (a) To be licensed as a licensed independent clinical social worker, an applicant for licensure under this section must provide evidence satisfactory to the board that the individual has:

(1) completed a graduate degree in social work from a program accredited by the Council on Social Work Education, the Canadian Association of Schools of Social Work, or a similar accrediting body designated by the board; or

(2) completed a graduate degree and is a mental health professional according to section 245.462, subdivision 18~~, clauses (1) to (6)~~.

(b) To be licensed as a licensed independent clinical social worker, an applicant for licensure under this section must provide evidence satisfactory to the board that the individual has:

(1) practiced clinical social work as defined in section 148E.010, subdivision 6, including both diagnosis and treatment, and has met the supervised practice requirements specified in sections 148E.100 to 148E.125, excluding the 1,800 hours of direct clinical client contact specified in section 148E.115, subdivision 1, except that supervised practice hours obtained prior to August 1, 2011, must meet the requirements in Minnesota Statutes 2010, sections 148D.100 to 148D.125;

(2) submitted a completed, signed application and the license fee in section 148E.180;

(3) for applications submitted electronically, provided an attestation as specified by the board;

(4) submitted the criminal background check fee and a form provided by the board authorizing a criminal background check;

(5) paid the license fee in section 148E.180; and

(6) not engaged in conduct that was or would be in violation of the standards of practice specified in Minnesota Statutes 2010, sections 148D.195 to 148D.240, and sections 148E.195 to 148E.240. If the applicant has engaged in conduct that was or would be in violation of the standards of practice, the board may take action according to sections 148E.255 to 148E.270.

(c) An application which is not completed, signed, and accompanied by the correct license fee must be returned to the applicant, along with any fee submitted, and is void.

(d) By submitting an application for licensure, an applicant authorizes the board to investigate any information provided or requested in the application. The board may request that the applicant provide additional information, verification, or documentation.

(e) Within one year of the time the board receives an application for licensure, the applicant must meet all the requirements and provide all of the information requested by the board.

Sec. 5. Minnesota Statutes 2018, section 148E.120, subdivision 2, is amended to read:

Subd. 2. **Alternate supervisors.** (a) The board may approve an alternate supervisor as determined in this subdivision. The board shall approve up to 25 percent of the required supervision hours by a licensed mental health professional who is competent and qualified to provide supervision according to the mental health professional's respective licensing board, as established by section 245.462, subdivision 18, ~~clauses (1) to (6),~~ or 245.4871, subdivision 27~~, clauses (1) to (6)~~.

(b) The board shall approve up to 100 percent of the required supervision hours by an alternate supervisor if the board determines that:

(1) there are five or fewer supervisors in the county where the licensee practices social work who meet the applicable licensure requirements in subdivision 1;

(2) the supervisor is an unlicensed social worker who is employed in, and provides the supervision in, a setting exempt from licensure by section 148E.065, and who has qualifications equivalent to the applicable requirements specified in sections 148E.100 to 148E.115;

(3) the supervisor is a social worker engaged in authorized social work practice in Iowa, Manitoba, North Dakota, Ontario, South Dakota, or Wisconsin, and has the qualifications equivalent to the applicable requirements in sections 148E.100 to 148E.115; or

(4) the applicant or licensee is engaged in nonclinical authorized social work practice outside of Minnesota and the supervisor meets the qualifications equivalent to the applicable requirements in sections 148E.100 to 148E.115, or the supervisor is an equivalent mental health professional, as determined by the board, who is credentialed by a state, territorial, provincial, or foreign licensing agency; or

(5) the applicant or licensee is engaged in clinical authorized social work practice outside of Minnesota and the supervisor meets qualifications equivalent to the applicable requirements in section 148E.115, or the supervisor is an equivalent mental health professional as determined by the board, who is credentialed by a state, territorial, provincial, or foreign licensing agency.

(c) In order for the board to consider an alternate supervisor under this section, the licensee must:

(1) request in the supervision plan and verification submitted according to section 148E.125 that an alternate supervisor conduct the supervision; and

(2) describe the proposed supervision and the name and qualifications of the proposed alternate supervisor. The board may audit the information provided to determine compliance with the requirements of this section.

Sec. 6. Minnesota Statutes 2018, section 148F.11, subdivision 1, is amended to read:

Subdivision 1. **Other professionals.** (a) Nothing in this chapter prevents members of other professions or occupations from performing functions for which they are qualified or licensed. This exception includes, but is not limited to: licensed physicians; registered nurses; licensed practical nurses; licensed psychologists and licensed psychological practitioners; members of the clergy provided such services are provided within the scope of regular ministries; American Indian medicine men and women; licensed attorneys; probation officers; licensed marriage and family therapists; licensed social workers; social workers employed by city, county, or state agencies; licensed professional counselors; licensed professional clinical counselors; licensed school counselors; registered occupational therapists or occupational therapy assistants; Upper Midwest Indian Council on Addictive Disorders (UMICAD) certified counselors when providing services to Native American people; city, county, or state employees when providing assessments or case management under Minnesota Rules, chapter 9530; and individuals defined in section 256B.0623, subdivision 5, clauses (1) ~~and (2)~~ to (4), providing integrated dual diagnosis treatment in adult mental health rehabilitative programs certified by the Department of Human Services under section 256B.0622 or 256B.0623.

(b) Nothing in this chapter prohibits technicians and resident managers in programs licensed by the Department of Human Services from discharging their duties as provided in Minnesota Rules, chapter 9530.

(c) Any person who is exempt from licensure under this section must not use a title incorporating the words "alcohol and drug counselor" or "licensed alcohol and drug counselor" or otherwise hold himself or herself out to the public by any title or description stating or implying that he or she is engaged in the practice of alcohol and drug counseling, or that he or she is licensed to engage in the practice of alcohol and drug counseling, unless that person is also licensed as an alcohol and drug counselor. Persons engaged in the practice of alcohol and drug counseling are not exempt from the board's jurisdiction solely by the use of one of the titles in paragraph (a).

Sec. 7. Minnesota Statutes 2018, section 245.462, subdivision 6, is amended to read:

Subd. 6. **Community support services program.** "Community support services program" means services, other than inpatient or residential treatment services, provided or coordinated by an identified program and staff under the ~~clinical~~ treatment supervision of a mental health professional designed to help adults with serious and persistent mental illness to function and remain in the community. A community support services program includes:

(1) client outreach,

(2) medication monitoring,

(3) assistance in independent living skills,

(4) development of employability and work-related opportunities,

(5) crisis assistance,

(6) psychosocial rehabilitation,

(7) help in applying for government benefits, and

(8) housing support services.

The community support services program must be coordinated with the case management services specified in section 245.4711.

Sec. 8. Minnesota Statutes 2018, section 245.462, subdivision 8, is amended to read:

Subd. 8. **Day treatment services.** "Day treatment," "day treatment services," or "day treatment program" means ~~a structured program of treatment and care provided to an adult in or by: (1) a hospital accredited by the joint commission on accreditation of health organizations and licensed under sections 144.50 to 144.55; (2) a community mental health center under section 245.62; or (3) an entity that is under contract with the county board to operate a program that meets the requirements of section 245.4712, subdivision 2, and~~

~~Minnesota Rules, parts 9505.0170 to 9505.0475. Day treatment consists of group psychotherapy and other intensive therapeutic services that are provided at least two days a week by a multidisciplinary staff under the clinical supervision of a mental health professional. Day treatment may include education and consultation provided to families and other individuals as part of the treatment process. The services are aimed at stabilizing the adult's mental health status, providing mental health services, and developing and improving the adult's independent living and socialization skills. The goal of day treatment is to reduce or relieve mental illness and to enable the adult to live in the community. Day treatment services are not a part of inpatient or residential treatment services. Day treatment services are distinguished from day care by their structured therapeutic program of psychotherapy services. The commissioner may limit medical assistance reimbursement for day treatment to 15 hours per week per person~~ the treatment services described under section 256B.0625, subdivision 23.

Sec. 9. Minnesota Statutes 2018, section 245.462, subdivision 9, is amended to read:

Subd. 9. **Diagnostic assessment.** ~~(a)~~ "Diagnostic assessment" ~~has the meaning given in Minnesota Rules, part 9505.0370, subpart 11, and is delivered as provided in Minnesota Rules, part 9505.0372, subpart 1, items A, B, C, and E. Diagnostic assessment includes a standard, extended, or brief diagnostic assessment, or an adult update~~ means the assessment described under section 256B.0671, subdivisions 2 to 4.

~~(b) A brief diagnostic assessment must include a face-to-face interview with the client and a written evaluation of the client by a mental health professional or a clinical trainee, as provided in Minnesota Rules, part 9505.0371, subpart 5, item C. The professional or clinical trainee must gather initial components of a standard diagnostic assessment, including the client's:~~

~~(1) age;~~

~~(2) description of symptoms, including reason for referral;~~

~~(3) history of mental health treatment;~~

~~(4) cultural influences and their impact on the client; and~~

~~(5) mental status examination.~~

~~(c) On the basis of the initial components, the professional or clinical trainee must draw a provisional clinical hypothesis. The clinical hypothesis may be used to address the client's immediate needs or presenting problem.~~

~~(d) Treatment sessions conducted under authorization of a brief assessment may be used to gather additional information necessary to complete a standard diagnostic assessment or an extended diagnostic assessment.~~

~~(e) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1), unit (b), prior to completion of a client's initial diagnostic assessment, a client is eligible for psychological testing as part of the diagnostic process.~~

~~(f) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1), unit (c), prior to completion of a client's initial diagnostic assessment, but in conjunction with the diagnostic assessment process, a client is eligible for up to three individual or family psychotherapy sessions or family psychoeducation sessions or a combination of the above sessions not to exceed three sessions.~~

~~(g) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item B, subitem (3), unit (a), a brief diagnostic assessment may be used for a client's family who requires a language interpreter to participate in the assessment.~~

Sec. 10. Minnesota Statutes 2018, section 245.462, subdivision 14, is amended to read:

Subd. 14. **Individual treatment plan.** "Individual treatment plan" means ~~a written plan of intervention, treatment, and services for an adult with mental illness that is developed by a service provider under the clinical supervision of a mental health professional on the basis of a diagnostic assessment. The plan identifies goals and objectives of treatment, treatment strategy, a schedule for accomplishing treatment goals and objectives, and the individual responsible for providing treatment to the adult with mental illness~~ the individual treatment plan described under section 256B.0671, subdivisions 5 and 6.

Sec. 11. Minnesota Statutes 2018, section 245.462, subdivision 17, is amended to read:

Subd. 17. **Mental health practitioner.** ~~(a)~~ "Mental health practitioner" means a person ~~providing services to adults with mental illness or children with emotional disturbance who is qualified in at least one of the ways described in paragraphs (b) to (g). A mental health practitioner for a child client must have training working with children. A mental health practitioner for an adult client must have training working with adults~~ qualified according to section 245I.16, subdivision 4.

~~(b) For purposes of this subdivision, a practitioner is qualified through relevant coursework if the practitioner completes at least 30 semester hours or 45 quarter hours in behavioral sciences or related fields and:~~

~~(1) has at least 2,000 hours of supervised experience in the delivery of services to adults or children with:~~

~~(i) mental illness, substance use disorder, or emotional disturbance; or~~

~~(ii) traumatic brain injury or developmental disabilities and completes training on mental illness, recovery from mental illness, mental health de-escalation techniques, co-occurring mental illness and substance abuse, and psychotropic medications and side effects;~~

~~(2) is fluent in the non-English language of the ethnic group to which at least 50 percent of the practitioner's clients belong, completes 40 hours of training in the delivery of services to adults with mental illness or children with emotional disturbance, and receives clinical supervision from a mental health professional at least once a week until the requirement of 2,000 hours of supervised experience is met;~~

~~(3) is working in a day treatment program under section 245.4712, subdivision 2; or~~

~~(4) has completed a practicum or internship that (i) requires direct interaction with adults or children served, and (ii) is focused on behavioral sciences or related fields.~~

~~(c) For purposes of this subdivision, a practitioner is qualified through work experience if the person:~~

~~(1) has at least 4,000 hours of supervised experience in the delivery of services to adults or children with:~~

~~(i) mental illness, substance use disorder, or emotional disturbance; or~~

~~(ii) traumatic brain injury or developmental disabilities and completes training on mental illness, recovery from mental illness, mental health de-escalation techniques, co-occurring mental illness and substance abuse, and psychotropic medications and side effects; or~~

~~(2) has at least 2,000 hours of supervised experience in the delivery of services to adults or children with:~~

~~(i) mental illness, emotional disturbance, or substance use disorder, and receives clinical supervision as required by applicable statutes and rules from a mental health professional at least once a week until the requirement of 4,000 hours of supervised experience is met; or~~

~~(ii) traumatic brain injury or developmental disabilities; completes training on mental illness, recovery from mental illness, mental health de-escalation techniques, co-occurring mental illness and substance abuse, and psychotropic medications and side effects; and receives clinical supervision as required by applicable statutes and rules at least once a week~~

~~from a mental health professional until the requirement of 4,000 hours of supervised experience is met.~~

~~(d) For purposes of this subdivision, a practitioner is qualified through a graduate student internship if the practitioner is a graduate student in behavioral sciences or related fields and is formally assigned by an accredited college or university to an agency or facility for clinical training.~~

~~(e) For purposes of this subdivision, a practitioner is qualified by a bachelor's or master's degree if the practitioner:~~

~~(1) holds a master's or other graduate degree in behavioral sciences or related fields; or~~

~~(2) holds a bachelor's degree in behavioral sciences or related fields and completes a practicum or internship that (i) requires direct interaction with adults or children served, and (ii) is focused on behavioral sciences or related fields.~~

~~(f) For purposes of this subdivision, a practitioner is qualified as a vendor of medical care if the practitioner meets the definition of vendor of medical care in section 256B.02, subdivision 7, paragraphs (b) and (c), and is serving a federally recognized tribe.~~

~~(g) For purposes of medical assistance coverage of diagnostic assessments, explanations of findings, and psychotherapy under section 256B.0625, subdivision 65, a mental health practitioner working as a clinical trainee means that the practitioner's clinical supervision experience is helping the practitioner gain knowledge and skills necessary to practice effectively and independently. This may include supervision of direct practice, treatment team collaboration, continued professional learning, and job management. The practitioner must also:~~

~~(1) comply with requirements for licensure or board certification as a mental health professional, according to the qualifications under Minnesota Rules, part 9505.0371, subpart 5, item A, including supervised practice in the delivery of mental health services for the treatment of mental illness; or~~

~~(2) be a student in a bona fide field placement or internship under a program leading to completion of the requirements for licensure as a mental health professional according to the qualifications under Minnesota Rules, part 9505.0371, subpart 5, item A.~~

~~(h) For purposes of this subdivision, "behavioral sciences or related fields" has the meaning given in section 256B.0623, subdivision 5, paragraph (d).~~

~~(i) Notwithstanding the licensing requirements established by a health-related licensing board, as defined in section 214.01, subdivision 2, this subdivision supersedes any other statute or rule.~~

Sec. 12. Minnesota Statutes 2018, section 245.462, subdivision 18, is amended to read:

Subd. 18. **Mental health professional.** "Mental health professional" means a person ~~providing clinical services in the treatment of mental illness who is qualified in at least one of the following ways:~~ qualified according to section 245I.16, subdivision 2.

~~(1) in psychiatric nursing: a registered nurse who is licensed under sections 148.171 to 148.285; and:~~

~~(i) who is certified as a clinical specialist or as a nurse practitioner in adult or family psychiatric and mental health nursing by a national nurse certification organization; or~~

~~(ii) who has a master's degree in nursing or one of the behavioral sciences or related fields from an accredited college or university or its equivalent, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;~~

~~(2) in clinical social work: a person licensed as an independent clinical social worker under chapter 148D, or a person with a master's degree in social work from an accredited college or university, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;~~

~~(3) in psychology: an individual licensed by the Board of Psychology under sections 148.88 to 148.98 who has stated to the Board of Psychology competencies in the diagnosis and treatment of mental illness;~~

~~(4) in psychiatry: a physician licensed under chapter 147 and certified by the American Board of Psychiatry and Neurology or eligible for board certification in psychiatry, or an osteopathic physician licensed under chapter 147 and certified by the American Osteopathic Board of Neurology and Psychiatry or eligible for board certification in psychiatry;~~

~~(5) in marriage and family therapy: the mental health professional must be a marriage and family therapist licensed under sections 148B.29 to 148B.39 with at least two years of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;~~

~~(6) in licensed professional clinical counseling, the mental health professional shall be a licensed professional clinical counselor under section 148B.5301 with at least 4,000 hours~~

~~of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness; or~~

~~(7) in allied fields: a person with a master's degree from an accredited college or university in one of the behavioral sciences or related fields, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness.~~

Sec. 13. Minnesota Statutes 2018, section 245.462, subdivision 21, is amended to read:

Subd. 21. **Outpatient services.** "Outpatient services" means mental health services, excluding day treatment and community support services programs, provided by or under the ~~clinical~~ treatment supervision of a mental health professional to adults with mental illness who live outside a hospital. Outpatient services include clinical activities such as individual, group, and family therapy; individual treatment planning; diagnostic assessments; medication management; and psychological testing.

Sec. 14. Minnesota Statutes 2018, section 245.462, subdivision 23, is amended to read:

Subd. 23. **Residential treatment.** "Residential treatment" means a 24-hour-a-day program under the ~~clinical~~ treatment supervision of a mental health professional, in a community residential setting other than an acute care hospital or regional treatment center inpatient unit, that must be licensed as a residential treatment program for adults with mental illness under Minnesota Rules, parts 9520.0500 to 9520.0670, or other rules adopted by the commissioner.

Sec. 15. Minnesota Statutes 2018, section 245.462, is amended by adding a subdivision to read:

Subd. 27. **Treatment supervision.** "Treatment supervision" means the treatment supervision described under section 245I.18.

Sec. 16. Minnesota Statutes 2018, section 245.467, subdivision 2, is amended to read:

Subd. 2. **Diagnostic assessment.** ~~All providers of residential, acute care hospital inpatient, and regional treatment centers must complete a diagnostic assessment for each of their clients within five days of admission. Providers of day treatment services must complete a diagnostic assessment within five days after the adult's second visit or within 30 days after intake, whichever occurs first. In cases where a diagnostic assessment is available and has been completed within three years preceding admission, only an adult diagnostic assessment update is necessary. An "adult diagnostic assessment update" means a written summary by~~

~~a mental health professional of the adult's current mental health status and service needs and includes a face-to-face interview with the adult. If the adult's mental health status has changed markedly since the adult's most recent diagnostic assessment, a new diagnostic assessment is required. Compliance with the provisions of this subdivision does not ensure eligibility for medical assistance reimbursement under chapter 256B.~~ Providers of services governed by this section shall complete a diagnostic assessment according to the standards of section 256B.0671, including for services to a person not eligible for medical assistance.

Sec. 17. Minnesota Statutes 2018, section 245.467, subdivision 3, is amended to read:

Subd. 3. **Individual treatment plans.** ~~All providers of outpatient services, day treatment services, residential treatment, acute care hospital inpatient treatment, and all regional treatment centers must develop an individual treatment plan for each of their adult clients. The individual treatment plan must be based on a diagnostic assessment. To the extent possible, the adult client shall be involved in all phases of developing and implementing the individual treatment plan. Providers of residential treatment and acute care hospital inpatient treatment, and all regional treatment centers must develop the individual treatment plan within ten days of client intake and must review the individual treatment plan every 90 days after intake. Providers of day treatment services must develop the individual treatment plan before the completion of five working days in which service is provided or within 30 days after the diagnostic assessment is completed or obtained, whichever occurs first. Providers of outpatient services must develop the individual treatment plan within 30 days after the diagnostic assessment is completed or obtained or by the end of the second session of an outpatient service, not including the session in which the diagnostic assessment was provided, whichever occurs first. Outpatient and day treatment services providers must review the individual treatment plan every 90 days after intake.~~ Providers of services governed by this section shall complete an individual treatment plan according to the standards of section 256B.0671, subdivisions 5 and 6, including for services to a person not eligible for medical assistance.

Sec. 18. Minnesota Statutes 2018, section 245.469, subdivision 1, is amended to read:

Subdivision 1. **Availability of emergency services.** ~~By July 1, 1988,~~ County boards must provide or contract for enough emergency services within the county to meet the needs of adults in the county who are experiencing an emotional crisis or mental illness. Clients may be required to pay a fee according to section 245.481. Emergency service providers shall not delay the timely provision of emergency service because of delays in determining this fee or because of the unwillingness or inability of the client to pay the fee. Emergency

services must include assessment, crisis intervention, and appropriate case disposition. A tribal authority that accepts crisis grant funding has the same responsibilities as county boards within the tribal authority's designated service area. Emergency services must:

(1) promote the safety and emotional stability of adults with mental illness or emotional crises;

(2) minimize further deterioration of adults with mental illness or emotional crises;

(3) help adults with mental illness or emotional crises to obtain ongoing care and treatment; ~~and~~

(4) prevent placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet client needs~~.~~; and

(5) provide support, psychoeducation, and referrals to family members, friends, service providers, or other third parties on behalf of a recipient in need of emergency services.

Sec. 19. Minnesota Statutes 2018, section 245.469, subdivision 2, is amended to read:

Subd. 2. **Specific requirements.** (a) The county board shall require that all service providers of emergency services to adults with mental illness provide immediate direct access to a mental health professional during regular business hours. For evenings, weekends, and holidays, the service may be by direct toll-free telephone access to a mental health professional, a clinical trainee, or a mental health practitioner~~, or until January 1, 1991, a designated person with training in human services who receives clinical supervision from a mental health professional~~.

(b) The commissioner may waive the requirement in paragraph (a) that the evening, weekend, and holiday service be provided by a mental health professional, clinical trainee, or mental health practitioner ~~after January 1, 1991,~~ if the county documents that:

(1) mental health professionals, clinical trainees, or mental health practitioners are unavailable to provide this service;

(2) services are provided by a designated person with training in human services who receives ~~clinical~~ treatment supervision from a mental health professional; and

(3) the service provider is not also the provider of fire and public safety emergency services.

(c) The commissioner may waive the requirement in paragraph (b), clause (3), that the evening, weekend, and holiday service not be provided by the provider of fire and public safety emergency services if:

(1) every person who will be providing the first telephone contact has received at least eight hours of training on emergency mental health services reviewed by the state advisory council on mental health and then approved by the commissioner;

(2) every person who will be providing the first telephone contact will annually receive at least four hours of continued training on emergency mental health services reviewed by the state advisory council on mental health and then approved by the commissioner;

(3) the local social service agency has provided public education about available emergency mental health services and can assure potential users of emergency services that their calls will be handled appropriately;

(4) the local social service agency agrees to provide the commissioner with accurate data on the number of emergency mental health service calls received;

(5) the local social service agency agrees to monitor the frequency and quality of emergency services; and

(6) the local social service agency describes how it will comply with paragraph (d).

(d) Whenever emergency service during nonbusiness hours is provided by anyone other than a mental health professional, a mental health professional must be available on call for an emergency assessment and crisis intervention services, and must be available for at least telephone consultation within 30 minutes.

Sec. 20. Minnesota Statutes 2018, section 245.470, subdivision 1, is amended to read:

Subdivision 1. **Availability of outpatient services.** (a) County boards must provide or contract for enough outpatient services within the county to meet the needs of adults with mental illness residing in the county. Services may be provided directly by the county through county-operated mental health centers or mental health clinics approved by the commissioner under section 245.69, subdivision 2; by contract with privately operated mental health centers or mental health clinics approved by the commissioner under section 245.69, subdivision 2; by contract with hospital mental health outpatient programs certified by the Joint Commission on Accreditation of Hospital Organizations; or by contract with a licensed mental health professional ~~as defined in section 245.462, subdivision 18, clauses (1) to (6)~~. Clients may be required to pay a fee according to section 245.481. Outpatient services include:

(1) conducting diagnostic assessments;

(2) conducting psychological testing;

(3) developing or modifying individual treatment plans;

(4) making referrals and recommending placements as appropriate;

(5) treating an adult's mental health needs through therapy;

(6) prescribing and managing medication and evaluating the effectiveness of prescribed medication; and

(7) preventing placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet client needs.

(b) County boards may request a waiver allowing outpatient services to be provided in a nearby trade area if it is determined that the client can best be served outside the county.

Sec. 21. Minnesota Statutes 2018, section 245.4712, subdivision 2, is amended to read:

Subd. 2. **Day treatment services provided.** (a) Day treatment services must be developed as a part of the community support services available to adults with serious and persistent mental illness residing in the county. Adults may be required to pay a fee according to section 245.481. Day treatment services must be designed to:

(1) provide a structured environment for treatment;

(2) provide support for residing in the community;

(3) prevent placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet client need;

(4) coordinate with or be offered in conjunction with a local education agency's special education program; and

(5) operate on a continuous basis throughout the year.

(b) For purposes of complying with medical assistance requirements, an adult day treatment program must comply with the method of ~~clinical~~ treatment supervision specified in ~~Minnesota Rules, part 9505.0371, subpart 4~~ section 245I.18. ~~The clinical supervision must be performed by a qualified supervisor who satisfies the requirements of Minnesota Rules, part 9505.0371, subpart 5.~~

A day treatment program must demonstrate compliance with this ~~clinical~~ treatment supervision requirement by the commissioner's review and approval of the program according to ~~Minnesota Rules, part 9505.0372, subpart 8~~ section 256B.0625, subdivision 23.

(c) County boards may request a waiver from including day treatment services if they can document that:

(1) an alternative plan of care exists through the county's community support services for clients who would otherwise need day treatment services;

(2) day treatment, if included, would be duplicative of other components of the community support services; and

(3) county demographics and geography make the provision of day treatment services cost ineffective and infeasible.

Sec. 22. Minnesota Statutes 2018, section 245.472, subdivision 2, is amended to read:

Subd. 2. **Specific requirements.** Providers of residential services must be licensed under applicable rules adopted by the commissioner and must ~~be clinically supervised~~ provide treatment supervision by a mental health professional. ~~Persons employed in facilities licensed under Minnesota Rules, parts 9520.0500 to 9520.0670, in the capacity of program director as of July 1, 1987, in accordance with Minnesota Rules, parts 9520.0500 to 9520.0670, may be allowed to continue providing clinical supervision within a facility, provided they continue to be employed as a program director in a facility licensed under Minnesota Rules, parts 9520.0500 to 9520.0670.~~

Sec. 23. Minnesota Statutes 2018, section 245.4863, is amended to read:

245.4863 INTEGRATED CO-OCCURRING DISORDER TREATMENT.

(a) The commissioner shall require individuals who perform chemical dependency assessments to screen clients for co-occurring mental health disorders, and staff who perform mental health diagnostic assessments to screen for co-occurring substance use disorders. Screening tools must be approved by the commissioner. If a client screens positive for a co-occurring mental health or substance use disorder, the individual performing the screening must document what actions will be taken in response to the results and whether further assessments must be performed.

(b) Notwithstanding paragraph (a), screening is not required when:

(1) the presence of co-occurring disorders was documented for the client in the past 12 months;

(2) the client is currently receiving co-occurring disorders treatment;

(3) the client is being referred for co-occurring disorders treatment; or

(4) a mental health professional, as ~~defined in Minnesota Rules, part 9505.0370, subpart 18~~ provided by section 245I.16, subdivision 2, who is competent to perform diagnostic

assessments of co-occurring disorders is performing a diagnostic assessment that meets the requirements in Minnesota Rules, part 9533.0090, subpart 5, to identify whether the client may have co-occurring mental health and chemical dependency disorders. If an individual is identified to have co-occurring mental health and substance use disorders, the assessing mental health professional must document what actions will be taken to address the client's co-occurring disorders.

(c) The commissioner shall adopt rules as necessary to implement this section. The commissioner shall ensure that the rules are effective on July 1, 2013, thereby establishing a certification process for integrated dual disorder treatment providers and a system through which individuals receive integrated dual diagnosis treatment if assessed as having both a substance use disorder and either a serious mental illness or emotional disturbance.

(d) The commissioner shall apply for any federal waivers necessary to secure, to the extent allowed by law, federal financial participation for the provision of integrated dual diagnosis treatment to persons with co-occurring disorders.

Sec. 24. Minnesota Statutes 2018, section 245.4871, subdivision 9a, is amended to read:

Subd. 9a. **Crisis ~~assistance~~ planning.** "Crisis ~~assistance~~ planning" means ~~assistance to the child, the child's family, and all providers of services to the child to: recognize factors precipitating a mental health crisis, identify behaviors related to the crisis, and be informed of available resources to resolve the crisis. Crisis assistance requires the development of a plan which addresses prevention and intervention strategies to be used in a potential crisis. Other interventions include: (1) arranging for admission to acute care hospital inpatient treatment; (2) crisis placement; (3) community resources for follow-up; and (4) emotional support to the family during crisis. Crisis assistance does not include services designed to secure the safety of a child who is at risk of abuse or neglect or necessary emergency services.~~ the development of a written plan to assist a child's family with a potential crisis and is distinct from the immediate provision of mental health mobile crisis intervention services as defined in section 256B.0944. The plan must address prevention and intervention strategies to be used in a crisis. The plan identifies factors that might precipitate a crisis, behaviors related to the emergence of a crisis, and the resources available to resolve a crisis. The plan must include planning for the following potential needs: (1) arranging for admission to acute care hospital inpatient treatment; (2) crisis placement; (3) community resources for follow-up; and (4) emotional support to the family during crisis. Crisis planning excludes services designed to secure the safety of a child who is at risk of abuse or neglect or necessary emergency services.

Sec. 25. Minnesota Statutes 2018, section 245.4871, subdivision 10, is amended to read:

Subd. 10. **Day treatment services.** "Day treatment," "day treatment services," or "day treatment program" means a structured program of treatment and care provided to a child in:

(1) an outpatient hospital accredited by the Joint Commission on Accreditation of Health Organizations and licensed under sections 144.50 to 144.55;

(2) a community mental health center under section 245.62;

(3) an entity that is under contract with the county board to operate a program that meets the requirements of section 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475; ~~or~~

(4) an entity that operates a program that meets the requirements of section 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475, that is under contract with an entity that is under contract with a county board~~.~~; or

(5) an entity that operates a program certified under section 256B.0943.

Day treatment consists of group psychotherapy and other intensive therapeutic services that are provided for a minimum two-hour time block by a multidisciplinary staff under the clinical supervision of a mental health professional. Day treatment may include education and consultation provided to families and other individuals as an extension of the treatment process. The services are aimed at stabilizing the child's mental health status, and developing and improving the child's daily independent living and socialization skills. Day treatment services are distinguished from day care by their structured therapeutic program of psychotherapy services. Day treatment services are not a part of inpatient hospital or residential treatment services.

A day treatment service must be available to a child up to 15 hours a week throughout the year and must be coordinated with, integrated with, or part of an education program offered by the child's school.

Sec. 26. Minnesota Statutes 2018, section 245.4871, subdivision 11a, is amended to read:

Subd. 11a. **Diagnostic assessment.** ~~(a)~~ "Diagnostic assessment" ~~has the meaning given in Minnesota Rules, part 9505.0370, subpart 11, and is delivered as provided in Minnesota Rules, part 9505.0372, subpart 1, items A, B, C, and E. Diagnostic assessment includes a standard, extended, or brief diagnostic assessment, or an adult update.~~ means the assessment described under section 256B.0671, subdivisions 2 to 4.

~~(b) A brief diagnostic assessment must include a face-to-face interview with the client and a written evaluation of the client by a mental health professional or a clinical trainee, as provided in Minnesota Rules, part 9505.0371, subpart 5, item C. The professional or clinical trainee must gather initial components of a standard diagnostic assessment, including the client's:~~

~~(1) age;~~

~~(2) description of symptoms, including reason for referral;~~

~~(3) history of mental health treatment;~~

~~(4) cultural influences and their impact on the client; and~~

~~(5) mental status examination.~~

~~(c) On the basis of the brief components, the professional or clinical trainee must draw a provisional clinical hypothesis. The clinical hypothesis may be used to address the client's immediate needs or presenting problem.~~

~~(d) Treatment sessions conducted under authorization of a brief assessment may be used to gather additional information necessary to complete a standard diagnostic assessment or an extended diagnostic assessment.~~

~~(e) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1), unit (b), prior to completion of a client's initial diagnostic assessment, a client is eligible for psychological testing as part of the diagnostic process.~~

~~(f) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1), unit (c), prior to completion of a client's initial diagnostic assessment, but in conjunction with the diagnostic assessment process, a client is eligible for up to three individual or family psychotherapy sessions or family psychoeducation sessions or a combination of the above sessions not to exceed three sessions.~~

Sec. 27. Minnesota Statutes 2018, section 245.4871, subdivision 17, is amended to read:

Subd. 17. **Family community support services.** "Family community support services" means services provided under the ~~clinical~~ treatment supervision of a mental health professional and designed to help each child with severe emotional disturbance to function and remain with the child's family in the community. Family community support services do not include acute care hospital inpatient treatment, residential treatment services, or regional treatment center services. Family community support services include:

(1) client outreach to each child with severe emotional disturbance and the child's family;

(2) medication monitoring where necessary;

(3) assistance in developing independent living skills;

(4) assistance in developing parenting skills necessary to address the needs of the child with severe emotional disturbance;

(5) assistance with leisure and recreational activities;

(6) crisis assistance, including crisis placement and respite care;

(7) professional home-based family treatment;

(8) foster care with therapeutic supports;

(9) day treatment;

(10) assistance in locating respite care and special needs day care; and

(11) assistance in obtaining potential financial resources, including those benefits listed in section 245.4884, subdivision 5.

Sec. 28. Minnesota Statutes 2018, section 245.4871, subdivision 21, is amended to read:

Subd. 21. **Individual treatment plan.** "Individual treatment plan" means ~~a written plan of intervention, treatment, and services for a child with an emotional disturbance that is developed by a service provider under the clinical supervision of a mental health professional on the basis of a diagnostic assessment. An individual treatment plan for a child must be developed in conjunction with the family unless clinically inappropriate. The plan identifies goals and objectives of treatment, treatment strategy, a schedule for accomplishing treatment goals and objectives, and the individuals responsible for providing treatment to the child with an emotional disturbance~~ the individual treatment plan described under section 256B.0671, subdivisions 5 and 6.

Sec. 29. Minnesota Statutes 2018, section 245.4871, subdivision 26, is amended to read:

Subd. 26. **Mental health practitioner.** "Mental health practitioner" ~~has the meaning given in~~ means a person qualified according to section ~~245.462, subdivision 17~~ 245I.16, subdivision 4.

Sec. 30. Minnesota Statutes 2018, section 245.4871, subdivision 27, is amended to read:

Subd. 27. **Mental health professional.** "Mental health professional" means a person ~~providing clinical services in the diagnosis and treatment of children's emotional disorders. A mental health professional must have training and experience in working with children~~

~~consistent with the age group to which the mental health professional is assigned. A mental health professional must be qualified in at least one of the following ways:~~ qualified according to section 245I.16, subdivision 2.

~~(1) in psychiatric nursing, the mental health professional must be a registered nurse who is licensed under sections 148.171 to 148.285 and who is certified as a clinical specialist in child and adolescent psychiatric or mental health nursing by a national nurse certification organization or who has a master's degree in nursing or one of the behavioral sciences or related fields from an accredited college or university or its equivalent, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;~~

~~(2) in clinical social work, the mental health professional must be a person licensed as an independent clinical social worker under chapter 148D, or a person with a master's degree in social work from an accredited college or university, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental disorders;~~

~~(3) in psychology, the mental health professional must be an individual licensed by the board of psychology under sections 148.88 to 148.98 who has stated to the board of psychology competencies in the diagnosis and treatment of mental disorders;~~

~~(4) in psychiatry, the mental health professional must be a physician licensed under chapter 147 and certified by the American Board of Psychiatry and Neurology or eligible for board certification in psychiatry or an osteopathic physician licensed under chapter 147 and certified by the American Osteopathic Board of Neurology and Psychiatry or eligible for board certification in psychiatry;~~

~~(5) in marriage and family therapy, the mental health professional must be a marriage and family therapist licensed under sections 148B.29 to 148B.39 with at least two years of post-master's supervised experience in the delivery of clinical services in the treatment of mental disorders or emotional disturbances;~~

~~(6) in licensed professional clinical counseling, the mental health professional shall be a licensed professional clinical counselor under section 148B.5301 with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental disorders or emotional disturbances; or~~

~~(7) in allied fields, the mental health professional must be a person with a master's degree from an accredited college or university in one of the behavioral sciences or related fields,~~

~~with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of emotional disturbances.~~

Sec. 31. Minnesota Statutes 2018, section 245.4871, subdivision 29, is amended to read:

Subd. 29. **Outpatient services.** "Outpatient services" means mental health services, excluding day treatment and community support services programs, provided by or under the ~~clinical~~ treatment supervision of a mental health professional to children with emotional disturbances who live outside a hospital. Outpatient services include clinical activities such as individual, group, and family therapy; individual treatment planning; diagnostic assessments; medication management; and psychological testing.

Sec. 32. Minnesota Statutes 2018, section 245.4871, subdivision 32, is amended to read:

Subd. 32. **Residential treatment.** "Residential treatment" means a 24-hour-a-day program under the ~~clinical~~ treatment supervision of a mental health professional, in a community residential setting other than an acute care hospital or regional treatment center inpatient unit, that must be licensed as a residential treatment program for children with emotional disturbances under Minnesota Rules, parts 2960.0580 to 2960.0700, or other rules adopted by the commissioner.

Sec. 33. Minnesota Statutes 2018, section 245.4871, subdivision 34, is amended to read:

Subd. 34. **Therapeutic support of foster care.** "Therapeutic support of foster care" means the mental health training and mental health support services and ~~clinical~~ treatment supervision provided by a mental health professional to foster families caring for children with severe emotional disturbance to provide a therapeutic family environment and support for the child's improved functioning. Therapeutic support of foster care includes services provided under section 256B.0946.

Sec. 34. Minnesota Statutes 2018, section 245.4876, subdivision 2, is amended to read:

Subd. 2. **Diagnostic assessment.** ~~All residential treatment facilities and acute care hospital inpatient treatment facilities that provide mental health services for children must complete a diagnostic assessment for each of their child clients within five working days of admission. Providers of day treatment services for children must complete a diagnostic assessment within five days after the child's second visit or 30 days after intake, whichever occurs first. In cases where a diagnostic assessment is available and has been completed within 180 days preceding admission, only updating is necessary. "Updating" means a~~

~~written summary by a mental health professional of the child's current mental health status and service needs. If the child's mental health status has changed markedly since the child's most recent diagnostic assessment, a new diagnostic assessment is required. Compliance with the provisions of this subdivision does not ensure eligibility for medical assistance reimbursement under chapter 256B.~~ Providers of services governed by this section shall complete a diagnostic assessment according to the standards of section 256B.0671, including for services to a person not eligible for medical assistance.

Sec. 35. Minnesota Statutes 2018, section 245.4876, subdivision 3, is amended to read:

Subd. 3. **Individual treatment plans.** ~~All providers of outpatient services, day treatment services, professional home-based family treatment, residential treatment, and acute care hospital inpatient treatment, and all regional treatment centers that provide mental health services for children must develop an individual treatment plan for each child client. The individual treatment plan must be based on a diagnostic assessment. To the extent appropriate, the child and the child's family shall be involved in all phases of developing and implementing the individual treatment plan. Providers of residential treatment, professional home-based family treatment, and acute care hospital inpatient treatment, and regional treatment centers must develop the individual treatment plan within ten working days of client intake or admission and must review the individual treatment plan every 90 days after intake, except that the administrative review of the treatment plan of a child placed in a residential facility shall be as specified in sections 260C.203 and 260C.212, subdivision 9. Providers of day treatment services must develop the individual treatment plan before the completion of five working days in which service is provided or within 30 days after the diagnostic assessment is completed or obtained, whichever occurs first. Providers of outpatient services must develop the individual treatment plan within 30 days after the diagnostic assessment is completed or obtained or by the end of the second session of an outpatient service, not including the session in which the diagnostic assessment was provided, whichever occurs first. Providers of outpatient and day treatment services must review the individual treatment plan every 90 days after intake.~~ Providers of services governed by this section shall complete an individual treatment plan according to the standards of section 256B.0671, subdivisions 5 and 6, including for services to a person not eligible for medical assistance.

Sec. 36. Minnesota Statutes 2018, section 245.4879, subdivision 1, is amended to read:

Subdivision 1. **Availability of emergency services.** County boards must provide or contract for enough mental health emergency services within the county to meet the needs

of children, and children's families when clinically appropriate, in the county who are experiencing an emotional crisis or emotional disturbance. The county board shall ensure that parents, providers, and county residents are informed about when and how to access emergency mental health services for children. A child or the child's parent may be required to pay a fee according to section 245.481. Emergency service providers shall not delay the timely provision of emergency service because of delays in determining this fee or because of the unwillingness or inability of the parent to pay the fee. Emergency services must include assessment, crisis intervention, and appropriate case disposition. A tribal authority that accepts crisis grant funding has the same responsibilities as county boards within the tribal authority's designated service area. Emergency services must:

(1) promote the safety and emotional stability of children with emotional disturbances or emotional crises;

(2) minimize further deterioration of the child with emotional disturbance or emotional crisis;

(3) help each child with an emotional disturbance or emotional crisis to obtain ongoing care and treatment; ~~and~~

(4) prevent placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet the child's needs~~.~~; and

(5) provide support, psychoeducation, and referrals to family members, service providers, or other third parties on behalf of a client in need of emergency services.

Sec. 37. Minnesota Statutes 2018, section 245.4879, subdivision 2, is amended to read:

Subd. 2. **Specific requirements.** (a) The county board shall require that all service providers of emergency services to the child with an emotional disturbance provide immediate direct access to a mental health professional during regular business hours. For evenings, weekends, and holidays, the service may be by direct toll-free telephone access to a mental health professional, a clinical trainee, or a mental health practitioner~~, or until January 1, 1991, a designated person with training in human services who receives clinical supervision from a mental health professional~~.

(b) The commissioner may waive the requirement in paragraph (a) that the evening, weekend, and holiday service be provided by a mental health professional, clinical trainee, or mental health practitioner ~~after January 1, 1991,~~ if the county documents that:

(1) mental health professionals, clinical trainees, or mental health practitioners are unavailable to provide this service;

(2) services are provided by a designated person with training in human services who receives ~~clinical~~ treatment supervision from a mental health professional; and

(3) the service provider is not also the provider of fire and public safety emergency services.

(c) The commissioner may waive the requirement in paragraph (b), clause (3), that the evening, weekend, and holiday service not be provided by the provider of fire and public safety emergency services if:

(1) every person who will be providing the first telephone contact has received at least eight hours of training on emergency mental health services reviewed by the state advisory council on mental health and then approved by the commissioner;

(2) every person who will be providing the first telephone contact will annually receive at least four hours of continued training on emergency mental health services reviewed by the state advisory council on mental health and then approved by the commissioner;

(3) the local social service agency has provided public education about available emergency mental health services and can assure potential users of emergency services that their calls will be handled appropriately;

(4) the local social service agency agrees to provide the commissioner with accurate data on the number of emergency mental health service calls received;

(5) the local social service agency agrees to monitor the frequency and quality of emergency services; and

(6) the local social service agency describes how it will comply with paragraph (d).

(d) When emergency service during nonbusiness hours is provided by anyone other than a mental health professional, a mental health professional must be available on call for an emergency assessment and crisis intervention services, and must be available for at least telephone consultation within 30 minutes.

Sec. 38. Minnesota Statutes 2018, section 245.488, subdivision 1, is amended to read:

Subdivision 1. **Availability of outpatient services.** (a) County boards must provide or contract for enough outpatient services within the county to meet the needs of each child with emotional disturbance residing in the county and the child's family. Services may be provided directly by the county through county-operated mental health centers or mental health clinics approved by the commissioner under section 245.69, subdivision 2; by contract with privately operated mental health centers or mental health clinics approved by the

commissioner under section 245.69, subdivision 2; by contract with hospital mental health outpatient programs certified by the Joint Commission on Accreditation of Hospital Organizations; or by contract with a licensed mental health professional ~~as defined in section 245.4871, subdivision 27, clauses (1) to (6)~~. A child or a child's parent may be required to pay a fee based in accordance with section 245.481. Outpatient services include:

(1) conducting diagnostic assessments;

(2) conducting psychological testing;

(3) developing or modifying individual treatment plans;

(4) making referrals and recommending placements as appropriate;

(5) treating the child's mental health needs through therapy; and

(6) prescribing and managing medication and evaluating the effectiveness of prescribed medication.

(b) County boards may request a waiver allowing outpatient services to be provided in a nearby trade area if it is determined that the child requires necessary and appropriate services that are only available outside the county.

(c) Outpatient services offered by the county board to prevent placement must be at the level of treatment appropriate to the child's diagnostic assessment.

Sec. 39. Minnesota Statutes 2018, section 245.696, is amended by adding a subdivision to read:

Subd. 3. **Certification of mental health peer specialists and mental health family peer specialists.** The commissioner shall develop a process to certify mental health peer specialists and mental health family peer specialists according to federal guidelines and section 245I.16, subdivisions 10 to 13, for a provider entity to bill for reimbursable services. The training and certification curriculum must teach individuals specific skills relevant to providing peer support as appropriate for individual or family peers.

Sec. 40. **[245I.01] PURPOSE AND CITATION.**

Subdivision 1. **Citation.** This chapter may be cited as the "Mental Health Uniform Service Standards Act."

Subd. 2. **Purpose.** In accordance with sections 245.461 and 245.487, to create a system of mental health care that is unified, accountable, and comprehensive, and to promote the recovery of Minnesotans from mental illnesses, the state's public policy is to support quality

outpatient and residential mental health services reimbursable by health insurance programs, including medical assistance as well as commercial payers. Further, the state's public policy is to ensure the safety, rights, and well-being of individuals served in these programs.

Subd. 3. **Variances.** If the conditions in section 245A.04, subdivision 9, are met, the commissioner may grant variances to the requirements in this chapter that do not affect a client's health or safety.

Sec. 41. **[245I.02] DEFINITIONS.**

Subdivision 1. **Scope.** For purposes of this chapter the terms in this section have the meanings given them.

Subd. 2. **Approval.** "Approval" means the documented review of, opportunity to request changes to, and agreement with a treatment document by a treatment supervisor or by a client. Approval may be demonstrated by written signature, secure electronic signature, or documented oral approval.

Subd. 3. **Behavioral sciences or related fields.** "Behavioral sciences or related fields" means an education from an accredited college or university in a field including but not limited to social work, psychology, sociology, community counseling, family social science, child development, child psychology, community mental health, addiction counseling, counseling and guidance, special education, and other similar fields as approved by the commissioner.

Subd. 4. **Certified rehabilitation specialist.** "Certified rehabilitation specialist" means a staff person qualified according to section 245I.16, subdivision 8.

Subd. 5. **Child.** "Child" means a client under 18 years of age, or a client under 21 years of age who is eligible for a service otherwise provided to persons under 18 years of age.

Subd. 6. **Client.** "Client" means a person who is seeking or receiving services regulated under this chapter. For the purpose of consent to services, this term includes a parent, guardian, or other individual authorized to consent to services by law.

Subd. 7. **Clinical trainee.** "Clinical trainee" means a staff person qualified according to section 245I.16, subdivision 6.

Subd. 8. **Clinician.** "Clinician" means a mental health professional or clinical trainee who is performing diagnostic assessment, testing, or psychotherapy.

Subd. 9. **Commissioner.** "Commissioner" means the commissioner of human services or the commissioner's designee.

Subd. 10. **Diagnostic assessment.** "Diagnostic assessment" means the evaluation and report of a client's potential diagnoses conducted by a clinician. For a client receiving publicly funded services, a diagnostic assessment must meet the standards of section 256B.0671, subdivisions 2 to 4.

Subd. 11. **Diagnostic formulation.** "Diagnostic formulation" means a written analysis and explanation of the information obtained from a clinical assessment to develop a hypothesis about the cause and nature of the presenting problems and identify a framework for developing the most suitable treatment approach.

Subd. 12. **Individual treatment plan.** "Individual treatment plan" means the formulation of planned services that are responsive to the needs and goals of a client. For a client receiving publicly funded services, an individual treatment plan must meet the standards of section 256B.0671, subdivisions 5 and 6.

Subd. 13. **Mental health behavioral aide.** "Mental health behavioral aide" means a staff person qualified according to section 245I.16, subdivision 16.

Subd. 14. **Mental health certified family peer specialist.** "Mental health certified family peer specialist" means a staff person qualified according to section 245I.16, subdivision 12.

Subd. 15. **Mental health certified peer specialist.** "Mental health certified peer specialist" means a staff person qualified according to section 245I.16, subdivision 10.

Subd. 16. **Mental health practitioner.** "Mental health practitioner" means a staff person qualified according to section 245I.16, subdivision 4.

Subd. 17. **Mental health professional.** "Mental health professional" means a staff person qualified according to section 245I.16, subdivision 2.

Subd. 18. **Mental health rehabilitation worker.** "Mental health rehabilitation worker" means a staff person qualified according to section 245I.16, subdivision 14.

Subd. 19. **Personnel file.** "Personnel file" means the set of records under section 245I.13, paragraph (a). Personnel files excludes information related to a person's employment not enumerated in section 245I.13.

Subd. 20. **Provider entity.** "Provider entity" means the organization, governmental unit, corporation, or other legal body that is enrolled, certified, licensed, or otherwise authorized by the commissioner to provide the services described in this chapter.

Subd. 21. **Responsivity factors.** "Responsivity factors" means the factors other than the diagnostic formulation that may modify an individual's treatment needs. This includes learning style, ability, cognitive function, cultural background, and personal circumstance. Documentation of responsivity factors includes an analysis of how an individual's strengths may be reflected in the planned delivery of services.

Subd. 22. **Risk factors.** "Risk factors" means factors that predispose a client to engage in potentially harmful behaviors to themselves or others.

Subd. 23. **Strengths.** "Strengths" means inner characteristics, virtues, external relationships, activities, and connections to resources that contribute to resilience and core competencies and can be built on to support recovery.

Subd. 24. **Trauma.** "Trauma" means an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. Trauma includes the cumulative emotional or psychological harm of group traumatic experiences, transmitted across generations within a community, often associated with racial and ethnic population groups in the country who have suffered major intergenerational losses.

Subd. 25. **Treatment supervision.** "Treatment supervision" means the direction and evaluation of individual assessment, treatment planning, and service delivery for each client when services are delivered by an individual who is not a licensed mental health professional or certified rehabilitation specialist as provided by section 245I.18.

Sec. 42. **[245I.10] TRAINING REQUIRED.**

Subdivision 1. **Training plan.** A provider entity must develop a plan to ensure that staff persons receive orientation and ongoing training. The plan must include:

(1) a formal process to evaluate the training needs of each staff person. An annual performance evaluation satisfies this requirement;

(2) a description of how the provider entity conducts annual training, including whether annual training is based on a staff person's hire date or a specified annual cycle determined by the program; and

(3) a description of how the provider entity determines when a staff person needs additional training, including the timelines in which the additional training is provided.

Subd. 2. **Documentation of orientation and training.** (a) The provider entity must provide training in accordance with the training plan and must document that orientation and training was provided. All training programs and materials used by the provider entity must be available for review by regulatory agencies. The documentation must include the following:

(1) topic covered in the training;

(2) identification of the trainee;

(3) name and credentials of the trainer;

(4) method of evaluating competency upon completion of training;

(5) date of training; and

(6) length of training, in hours.

(b) Documentation of a continuing education credit accepted by the governing health-related licensing board is sufficient for purposes of this subdivision.

Subd. 3. **Orientation.** (a) Before providing direct contact services, a staff person must receive orientation on:

(1) patient rights as identified in section 144.651;

(2) vulnerable adult and minor maltreatment requirements in sections 245A.65, subdivision 3; 626.556, subdivisions 2, 3, and 7; 626.557; and 626.5572;

(3) the Minnesota Health Records Act, including confidentiality, family engagement according to section 144.294, and client privacy;

(4) program policies and procedures;

(5) emergency procedures appropriate to the position, including but not limited to fires, inclement weather, missing persons, and medical emergencies;

(6) professional boundaries;

(7) behavior management, crisis intervention, and stabilization techniques;

(8) specific needs of individuals served by the program, including but not limited to developmental status, cognitive functioning, and physical and mental abilities; and

(9) training related to the specific activities and job functions for which the staff person is responsible to carry out, including documentation of the delivery of services.

(b) A staff person must receive orientation on the following topics within 90 calendar days of a staff person first providing direct contact services:

(1) trauma-informed care;

(2) family- and person-centered individual treatment plans, seeking partnership with parents and identified supports, and shared decision making and engagement;

(3) treatment for co-occurring substance use problems, including the definitions of co-occurring disorders, prevalence of co-occurring disorders, common signs and symptoms of co-occurring disorders, and the etiology of co-occurring disorders;

(4) psychotropic medications, side effects, and safe medication management;

(5) family systems and promoting culturally appropriate support networks;

(6) culturally responsive treatment practices;

(7) recovery concepts and principles;

(8) building resiliency through a strength-based approach;

(9) person-centered planning and positive support strategies; and

(10) other training relevant to the staff person's role and responsibilities.

(c) A provider entity may deem a staff person to have met an orientation requirement in paragraph (b) if the staff person has received equivalent postsecondary education in the previous four years or training experience in the previous two years. The training plan must describe the process and location for verification and documentation of previous training experience.

(d) A provider entity may deem a mental health professional to have met a requirement of paragraph (a), clauses (6) to (9), and paragraph (b) after an evaluation of the mental health professional's competency, including by interview.

Subd. 4. **Annual training.** (a) A provider entity shall ensure that staff persons who are not licensed mental health professionals receive 15 hours of training each year after the first year of employment.

(b) A licensed mental health professional must follow specific training requirements as determined by the professional's governing health-related licensing board.

(c) All staff persons, including licensed mental health professionals, must receive annual training on the topics in subdivision 3, paragraph (a), clauses (2) and (5).

(d) The selection of additional training topics must be based on program needs and staff persons' competency.

Subd. 5. **Training for services provided to children.** (a) Training and orientation required under this section for a staff person working with children must be aligned to the developmental characteristics of the children served in the program and address the needs of children in the context of the family, support system, and culture. This includes orientation under subdivision 3 on the following topics: (1) child development; (2) working with children and children's support systems; and (3) adverse childhood experiences, cognitive functioning, and physical and mental abilities.

(b) For a mental health behavioral aide, orientation in the first 90 days of service must include a parent team training utilizing a curriculum approved by the commissioner.

Sec. 43. **[245I.13] PERSONNEL FILES.**

(a) For each staff person, a provider entity shall maintain a personnel file that includes:

(1) verification of the staff person's qualifications including training, education, and licensure;

(2) documentation related to the staff person's background study;

(3) the date of hire;

(4) the effective date of specific duties and responsibilities including the date that the staff person begins direct contact with a client;

(5) documentation of orientation;

(6) records of training, license renewal, and educational activities completed during the staff person's employment;

(7) annual job performance evaluations; and

(8) records of clinical supervision, if applicable.

(b) Personnel files must be made accessible to the commissioner upon request. Personnel files must be readily accessible for review but need not be kept in a single location.

Sec. 44. **[245I.16] PROVIDER QUALIFICATIONS AND SCOPE OF PRACTICE.**

Subdivision 1. **Tribal providers.** For purposes of this section, a tribal entity may credential an individual under section 256B.02, subdivision 7, paragraphs (b) and (c).

Subd. 2. **Mental health professional qualifications.** The following individuals may provide services as a mental health professional:

(1) a registered nurse who is licensed under sections 148.171 to 148.285 and is certified as a (i) clinical nurse specialist in child or adolescent, family, or adult psychiatric and mental health nursing by a national certification organization, or (ii) nurse practitioner in adult or family psychiatric and mental health nursing by a national nurse certification organization;

(2) a licensed independent clinical social worker as defined in section 148E.050, subdivision 5;

(3) a psychologist licensed by the Board of Psychology under sections 148.88 to 148.98;

(4) a physician licensed under chapter 147 if the physician is: (i) certified by the American Board of Psychiatry and Neurology; (ii) certified by the American Osteopathic Board of Neurology and Psychiatry; or (iii) eligible for board certification in psychiatry;

(5) a marriage and family therapist licensed under sections 148B.29 to 148B.39; or

(6) a licensed professional clinical counselor licensed under section 148B.5301.

Subd. 3. **Mental health professional scope of practice.** A mental health professional shall maintain a valid license with the mental health professional's governing health-related licensing board and shall only provide services within the scope of practice as determined by the health-related licensing board.

Subd. 4. **Mental health practitioner qualifications.** (a) An individual who is qualified in at least one of the ways described in paragraphs (b) to (d) may serve as a mental health practitioner.

(b) An individual is qualified through relevant coursework if the individual completes at least 30 semester hours or 45 quarter hours in behavioral sciences or related fields and:

(1) has at least 2,000 hours of supervised experience in the delivery of services to adults or children with: (i) mental illness, substance use disorder, or emotional disturbance; or (ii) traumatic brain injury or developmental disabilities and completes training on mental illness, recovery from mental illness, mental health de-escalation techniques, co-occurring mental illness and substance use disorder, and psychotropic medications and side effects;

(2) is fluent in the non-English language of the ethnic group to which at least 50 percent of the individual's clients belong, completes 40 hours of training in the delivery of services to adults with mental illness or children with emotional disturbance, and receives treatment

supervision from a mental health professional at least once per week until the requirement of 2,000 hours of supervised experience is met;

(3) is working in a day treatment program under section 245.4712, subdivision 2; or

(4) has completed a practicum or internship that (i) requires direct interaction with adults or children served, and (ii) is focused on behavioral sciences or related fields.

(c) An individual is qualified through work experience if the individual:

(1) has at least 4,000 hours of supervised experience in the delivery of services to adults or children with: (i) mental illness, substance use disorder, or emotional disturbance; or (ii) traumatic brain injury or developmental disabilities and completes training on mental illness, recovery from mental illness, mental health de-escalation techniques, co-occurring mental illness and substance use disorder, and psychotropic medications and side effects; or

(2) has at least 2,000 hours of supervised experience in the delivery of services to adults or children with: (i) mental illness, emotional disturbance, or substance use disorder, and receives treatment supervision as required by applicable statutes and rules from a mental health professional at least once per week until the requirement of 4,000 hours of supervised experience is met; or (ii) traumatic brain injury or developmental disabilities, completes training on mental illness, recovery from mental illness, mental health de-escalation techniques, co-occurring mental illness and substance use disorder, and psychotropic medications and side effects, and receives treatment supervision as required by applicable statutes and rules at least once per week from a mental health professional until the requirement of 4,000 hours of supervised experience is met.

(d) An individual is qualified by a bachelor's or master's degree if the individual: (1) holds a master's or other graduate degree in behavioral sciences or related fields; or (2) holds a bachelor's degree in behavioral sciences or related fields and completes a practicum or internship that (i) requires direct interaction with adults or children served, and (ii) is focused on behavioral sciences or related fields.

Subd. 5. **Mental health practitioner scope of practice.** (a) A mental health practitioner must perform services under the treatment supervision of a mental health professional.

(b) A mental health practitioner may perform client education, functional assessments for adult clients, level of care assessments, rehabilitative interventions, and skills building; provide direction to a mental health rehabilitation worker or mental health behavioral aide; and propose individual treatment plans.

(c) A mental health practitioner who provides services according to section 256B.0624 or 256B.0944 may perform crisis assessment and intervention.

Subd. 6. **Clinical trainee qualifications.** (a) A clinical trainee is a staff person who is enrolled in or has completed an accredited graduate program of study intended to prepare the individual for independent licensure as a mental health professional and who: (1) participates in a practicum or internship supervised by a mental health professional; or (2) is completing postgraduate hours, according to the requirements of a health-related licensing board.

(b) A clinical trainee is responsible for notifying and applying to a health-related licensing board to ensure the requirements of the health-related licensing board are met. As permitted by a health-related licensing board, treatment supervision under this chapter may be integrated into a plan to meet the supervisory requirements of the health-related licensing board but does not supersede those requirements.

Subd. 7. **Clinical trainee scope of practice.** (a) A clinical trainee, under treatment supervision of a mental health professional, may perform psychotherapy, diagnostic assessments, and services that a mental health practitioner may deliver. A clinical trainee shall not provide treatment supervision. A clinical trainee may provide direction to a mental health behavioral aide or mental health rehabilitation worker.

(b) A clinical trainee shall not deliver services in violation of the practice act of a health-related licensing board, including failure to obtain licensure, if required.

Subd. 8. **Certified rehabilitation specialist qualifications.** A certified rehabilitation specialist shall have:

(1) a master's degree from an accredited college or university in behavioral sciences or related fields as defined in section 245I.02, subdivision 3;

(2) at least 4,000 hours of postmaster's supervised experience in the delivery of mental health services; and

(3) a valid national certification as a certified rehabilitation counselor or certified psychosocial rehabilitation practitioner.

Subd. 9. **Certified rehabilitation specialist scope of practice.** A certified rehabilitation specialist shall provide services based on a client's diagnostic assessment. A certified rehabilitation specialist may provide supervision for mental health certified peer specialists, mental health practitioners, and mental health rehabilitation workers, but is prohibited from performing a diagnostic assessment.

Subd. 10. **Mental health certified peer specialist qualifications.** A mental health certified peer specialist shall:

(1) be 21 years of age or older;

(2) have been diagnosed with a mental illness;

(3) be a current or former mental health services client; and

(4) have a valid certification as a mental health certified peer specialist according to section 245.696, subdivision 3.

Subd. 11. **Mental health certified peer specialist scope of practice.** A mental health certified peer specialist shall:

(1) provide peer support that is individualized to the client;

(2) promote recovery goals, self-sufficiency, self-advocacy, and the development of natural supports; and

(3) support the maintenance of skills learned in other services.

Subd. 12. **Mental health certified family peer specialist qualifications.** A mental health certified family peer specialist shall:

(1) be 21 years of age or older;

(2) have raised or be currently raising a child with a mental illness;

(3) have experience navigating the children's mental health system; and

(4) have a valid certification as a mental health certified family peer specialist according to section 245.696, subdivision 3.

Subd. 13. **Mental health certified family peer specialist scope of practice.** A mental health certified family peer specialist shall provide services to increase the child's ability to function better within the child's home, school, and community. The mental health certified family peer specialist shall:

(1) provide family peer support, to build on strengths of families and help families achieve desired outcomes;

(2) provide nonadversarial advocacy that encourages partnership and promotes positive change and growth;

(3) support families to advocate for culturally appropriate services for a child in each treatment setting;

(4) promote resiliency, self-advocacy, and development of natural supports;

(5) support the maintenance of skills learned in other services;

(6) establish and lead parent support groups;

(7) assist parents to develop coping and problem-solving skills; and

(8) educate parents on community resources, including resources that connect parents with similar experiences.

Subd. 14. **Mental health rehabilitation worker qualifications.** (a) A mental health rehabilitation worker shall (1) be 21 years of age or older; (2) have a high school diploma or equivalent; and (3) meet the qualification requirements in paragraph (b).

(b) In addition to the requirements of paragraph (a), a mental health rehabilitation worker shall also:

(1)(i) be fluent in the non-English language or competent in the culture of the ethnic group to which at least 20 percent of the mental health rehabilitation worker's clients belong;

(ii) during the first 2,000 hours of work, receive monthly documented individual treatment supervision by a mental health professional; and

(iii) receive direct observation in addition to the direct observation requirements of section 245I.18, subdivision 5, for a total of not less than twice per month for the first year of work;

(2) have an associate of arts degree;

(3) have two years of full-time postsecondary education or a total of 15 semester hours or 23 quarter hours in behavioral sciences or related fields;

(4) be a registered nurse;

(5) have within the previous ten years three years of personal life experience with mental illness;

(6) have within the previous ten years three years of life experience as a primary caregiver to an adult with a mental illness, traumatic brain injury, substance use disorder, or developmental disability; or

(7) have within the previous ten years 2,000 hours of supervised work experience in delivering mental health services to adults with a mental illness, traumatic brain injury, substance use disorder, or developmental disability.

(c) If the mental health rehabilitation worker provides crisis residential services, intensive residential treatment services, partial hospitalization, or day treatment services, the mental health rehabilitation worker shall: (1) satisfy paragraph (b), clause (1); and (2) have 40 hours of additional continuing education on mental health topics during the first year of employment.

Subd. 15. **Mental health rehabilitation worker scope of practice.** (a) A mental health rehabilitation worker under supervision of a mental health practitioner or mental health professional may provide rehabilitative mental health services identified in the client's individual treatment plan and individual behavior plan.

(b) A mental health rehabilitation worker who solely acts and is scheduled as overnight staff is exempt from the additional qualification requirements in subdivision 14, paragraphs (a), clause (3), and (b).

Subd. 16. **Mental health behavioral aide qualifications.** (a) A level 1 mental health behavioral aide shall:

(1) be 18 years of age or older; and

(2) have a high school diploma or commissioner of education-selected high school equivalency certification; or two years of experience as a primary caregiver to a child with severe emotional disturbance within the previous ten years.

(b) A level 2 mental health behavioral aide shall:

(1) be 18 years of age or older; and

(2) have an associate or bachelor's degree or be certified by a program under section 256B.0943, subdivision 8a.

Subd. 17. **Mental health behavioral aide scope of practice.** The mental health behavioral aid under supervision of a mental health professional may provide rehabilitative mental health services identified in the client's individual treatment plan and individual behavior plan.

Sec. 45. **[245I.18] TREATMENT SUPERVISION.**

Subdivision 1. **Generally.** (a) A provider entity shall ensure that a mental health professional provides treatment supervision for each staff person who provides services to a client and who is not a mental health professional or certified rehabilitation specialist. Treatment supervision shall be based on a staff person's written treatment supervision plan.

(b) Treatment supervision must focus on the client's treatment needs and the ability of the staff person receiving treatment supervision to provide services, including:

(1) review and evaluation of the interventions delivered;

(2) instruction on alternative strategies if a client is not achieving treatment goals;

(3) review and evaluation of assessments, treatment plans, and progress notes for accuracy and appropriateness;

(4) approval of diagnostic assessments and individual treatment plans within five business days of initial completion by the supervisee;

(5) instruction on the cultural norms or values of the clients and communities served by the provider entity and any impact on treatment;

(6) evaluation of and feedback on the competencies of direct service staff persons; and

(7) coaching, teaching, and practicing skills with staff persons.

(c) A treatment supervisor's responsibility for a supervisee is limited to services provided by the associated provider entity. If a supervisee is employed by multiple provider entities, each entity is responsible for furnishing the necessary treatment supervision.

Subd. 2. **Permitted modalities.** (a) Treatment supervision must be conducted face-to-face, including telemedicine, according to the Minnesota Telemedicine Act, sections 62A.67 to 62A.672.

(b) Treatment supervision may be conducted using individual, small group, or team modalities. "Individual supervision" means one or more mental health professionals and one staff person receiving treatment supervision. "Small group supervision" means one or more mental health professionals and two to six staff persons receiving treatment supervision. "Team supervision" is defined by the service lines for which it may be used.

Subd. 3. **Treatment supervision planning.** (a) A written treatment supervision plan shall be developed by a mental health professional who is qualified to provide treatment supervision and the staff person receiving the treatment supervision. The treatment supervision plan must be completed and implemented within 30 days of a new staff person's employment. The treatment supervision plan must be reviewed and updated at least annually.

(b) The treatment supervision plan must include:

(1) the name and qualifications of the staff person receiving treatment supervision;

(2) the name of the provider entity under which the staff person is receiving treatment supervision;

(3) the name and licensure of a mental health professional providing treatment supervision;

(4) the number of hours of individual and group supervision the staff person receiving treatment supervision must complete and the location of the record if the record is kept outside of an individual personnel file;

(5) procedures that the staff person receiving treatment supervision shall use to respond to client emergencies; and

(6) the authorized scope of practice for the staff person receiving treatment supervision, including a description of responsibilities with the provider entity, a description of client population, and treatment methods and modalities.

Subd. 4. **Treatment supervision record.** (a) A provider entity shall ensure treatment supervision is documented in each staff person's treatment supervision record.

(b) The treatment supervision record must include:

(1) the date and duration of the supervision;

(2) identification of the supervision type as individual, small group, or team supervision;

(3) the name of the mental health professional providing treatment supervision;

(4) subsequent actions that the staff person receiving treatment supervision shall take; and

(5) the date and signature of the mental health professional providing treatment supervision.

Subd. 5. **Direct observation of mental health rehabilitation workers and behavioral aides.** A mental health practitioner, clinical trainee, or mental health professional shall directly observe a mental health behavioral aide or a mental health rehabilitation worker while the mental health behavioral aide or mental health rehabilitation worker provides services to clients. The amount of direct observation shall be no less than twice per month for the first six months and once per month thereafter. The staff performing the observation shall approve the progress note for the service observed.

Sec. 46. **[245I.32] CLIENT FILES.**

Subdivision 1. **Generally.** A provider entity must maintain a file of current and accurate client records on the premises where the service is provided or coordinated. Each entry in the record must be signed and dated by the staff person making the entry.

Subd. 2. **Record retention.** A provider entity must retain client records of a discharged client for a minimum of seven years from the date of discharge. A provider entity that ceases to provide treatment service must retain client records for a minimum of seven years from the date the provider entity stopped providing the service and must notify the commissioner of the location of the client records and the name of the individual responsible for maintaining the client records.

Subd. 3. **Contents.** Client files must contain the following, as applicable:

(1) diagnostic assessments;

(2) functional assessments;

(3) individual treatment plans;

(4) individual abuse prevention plans;

(5) crisis plans;

(6) documentation of releases of information;

(7) emergency contacts for the client;

(8) documentation of the date of service; signature of the person providing the service; nature, extent, and units of service; and place of service delivery;

(9) record of all medication prescribed or administered by staff;

(10) documentation of any contact made with the client's other mental health providers, case manager, family members, primary caregiver, or legal representative or the reason the provider did not contact the client's family members or primary caregiver;

(11) documentation of any contact made with other persons interested in the client, including representatives of the courts, corrections systems, or schools;

(12) written information by the client that the client requests be included in the file;

(13) health care directive; and

(14) the date and reason the provider entity's services are discontinued.

Sec. 47. **[245I.33] DOCUMENTATION STANDARDS.**

Subdivision 1. **Generally.** As a condition of payment, a provider entity must ensure that documentation complies with this section and Minnesota Rules, parts 9505.2175 and 9505.2197. The department must recover medical assistance payments for a service not documented in a client file according to this section.

Subd. 2. **Documentation standards.** A provider entity must ensure that all documentation required under this chapter:

(1) is typed or legible, if handwritten;

(2) identifies the client or staff person on each page, as applicable;

(3) is signed and dated by the staff person who completes the documentation, including the staff person's credentials; and

(4) is cosigned and dated by the staff person providing treatment supervision as required under this chapter, including the staff person's credentials.

Subd. 3. **Progress notes.** A provider entity shall use a progress note to promptly document each occurrence of a mental health service provided to a client. A progress note must include the following:

(1) the type of service;

(2) the date of service, including the start and stop time;

(3) the location of service;

(4) the scope of service, including: (i) the goal and objective targeted; (ii) the intervention delivered and the methods used; (iii) the client's response or reaction to intervention; (iv) the plan for the next session; and (v) the service modality;

(5) the signature and the printed name and credentials of the staff person who provided the service;

(6) the mental health provider travel documentation requirements under section 256B.0625, if applicable; and

(7) other significant observations, including (i) current risk factors the client may be experiencing; (ii) emergency interventions; (iii) consultations with or referrals to other professionals, family, or significant others; (iv) a summary of the effectiveness of treatment, prognosis, or discharge planning; (v) test results and medications; or (vi) changes in mental or physical symptoms.

Sec. 48. Minnesota Statutes 2018, section 254B.05, subdivision 5, is amended to read:

Subd. 5. **Rate requirements.** (a) The commissioner shall establish rates for substance use disorder services and service enhancements funded under this chapter.

(b) Eligible substance use disorder treatment services include:

(1) outpatient treatment services that are licensed according to sections 245G.01 to 245G.17, or applicable tribal license;

(2) on July 1, 2018, or upon federal approval, whichever is later, comprehensive assessments provided according to sections 245.4863, paragraph (a), and 245G.05~~, and Minnesota Rules, part 9530.6422~~;

(3) on July 1, 2018, or upon federal approval, whichever is later, care coordination services provided according to section 245G.07, subdivision 1, paragraph (a), clause (6);

(4) on July 1, 2018, or upon federal approval, whichever is later, peer recovery support services provided according to section 245G.07, subdivision 1, paragraph (a), clause (5);

(5) on July 1, 2019, or upon federal approval, whichever is later, withdrawal management services provided according to chapter 245F;

(6) medication-assisted therapy services that are licensed according to sections 245G.01 to 245G.17 and 245G.22, or applicable tribal license;

(7) medication-assisted therapy plus enhanced treatment services that meet the requirements of clause (6) and provide nine hours of clinical services each week;

(8) high, medium, and low intensity residential treatment services that are licensed according to sections 245G.01 to 245G.17 and 245G.21 or applicable tribal license which provide, respectively, 30, 15, and five hours of clinical services each week;

(9) hospital-based treatment services that are licensed according to sections 245G.01 to 245G.17 or applicable tribal license and licensed as a hospital under sections 144.50 to 144.56;

(10) adolescent treatment programs that are licensed as outpatient treatment programs according to sections 245G.01 to 245G.18 or as residential treatment programs according to Minnesota Rules, parts 2960.0010 to 2960.0220, and 2960.0430 to 2960.0490, or applicable tribal license;

(11) high-intensity residential treatment services that are licensed according to sections 245G.01 to 245G.17 and 245G.21 or applicable tribal license, which provide 30 hours of clinical services each week provided by a state-operated vendor or to clients who have been

civilly committed to the commissioner, present the most complex and difficult care needs, and are a potential threat to the community; and

(12) room and board facilities that meet the requirements of subdivision 1a.

(c) The commissioner shall establish higher rates for programs that meet the requirements of paragraph (b) and one of the following additional requirements:

(1) programs that serve parents with their children if the program:

(i) provides on-site child care during the hours of treatment activity that:

(A) is licensed under chapter 245A as a child care center under Minnesota Rules, chapter 9503; or

(B) meets the licensure exclusion criteria of section 245A.03, subdivision 2, paragraph (a), clause (6), and meets the requirements under section 245G.19, subdivision 4; or

(ii) arranges for off-site child care during hours of treatment activity at a facility that is licensed under chapter 245A as:

(A) a child care center under Minnesota Rules, chapter 9503; or

(B) a family child care home under Minnesota Rules, chapter 9502;

(2) culturally specific programs as defined in section 254B.01, subdivision 4a, or programs or subprograms serving special populations, if the program or subprogram meets the following requirements:

(i) is designed to address the unique needs of individuals who share a common language, racial, ethnic, or social background;

(ii) is governed with significant input from individuals of that specific background; and

(iii) employs individuals to provide individual or group therapy, at least 50 percent of whom are of that specific background, except when the common social background of the individuals served is a traumatic brain injury or cognitive disability and the program employs treatment staff who have the necessary professional training, as approved by the commissioner, to serve clients with the specific disabilities that the program is designed to serve;

(3) programs that offer medical services delivered by appropriately credentialed health care staff in an amount equal to two hours per client per week if the medical needs of the client and the nature and provision of any medical services provided are documented in the client file; and

(4) programs that offer services to individuals with co-occurring mental health and chemical dependency problems if:

(i) the program meets the co-occurring requirements in section 245G.20;

(ii) 25 percent of the counseling staff are licensed mental health professionals, as defined in section 245.462, subdivision 18, ~~clauses (1) to (6),~~ or are students or licensing candidates under the supervision of a licensed alcohol and drug counselor supervisor and licensed mental health professional, except that no more than 50 percent of the mental health staff may be students or licensing candidates with time documented to be directly related to provisions of co-occurring services;

(iii) clients scoring positive on a standardized mental health screen receive a mental health diagnostic assessment within ten days of admission;

(iv) the program has standards for multidisciplinary case review that include a monthly review for each client that, at a minimum, includes a licensed mental health professional and licensed alcohol and drug counselor, and their involvement in the review is documented;

(v) family education is offered that addresses mental health and substance abuse disorders and the interaction between the two; and

(vi) co-occurring counseling staff shall receive eight hours of co-occurring disorder training annually.

(d) In order to be eligible for a higher rate under paragraph (c), clause (1), a program that provides arrangements for off-site child care must maintain current documentation at the chemical dependency facility of the child care provider's current licensure to provide child care services. Programs that provide child care according to paragraph (c), clause (1), must be deemed in compliance with the licensing requirements in section 245G.19.

(e) Adolescent residential programs that meet the requirements of Minnesota Rules, parts 2960.0430 to 2960.0490 and 2960.0580 to 2960.0690, are exempt from the requirements in paragraph (c), clause (4), items (i) to (iv).

(f) Subject to federal approval, chemical dependency services that are otherwise covered as direct face-to-face services may be provided via two-way interactive video. The use of two-way interactive video must be medically appropriate to the condition and needs of the person being served. Reimbursement shall be at the same rates and under the same conditions that would otherwise apply to direct face-to-face services. The interactive video equipment and connection must comply with Medicare standards in effect at the time the service is provided.

Sec. 49. Minnesota Statutes 2018, section 256B.0615, subdivision 1, is amended to read:

Subdivision 1. **Scope.** Medical assistance covers mental health certified peer specialist services~~, as established in subdivision 2, subject to federal approval, if provided to recipients who are eligible for services under sections 256B.0622, 256B.0623, and 256B.0624 and are~~ provided by a certified peer specialist who ~~has completed the training under subdivision 5~~ is qualified according to section 245I.16, subdivision 10.

Sec. 50. Minnesota Statutes 2018, section 256B.0616, subdivision 1, is amended to read:

Subdivision 1. **Scope.** Medical assistance covers mental health certified family peer specialists services~~, as established in subdivision 2, subject to federal approval, if provided to recipients who have an emotional disturbance or severe emotional disturbance under chapter 245,~~ and are provided by a certified family peer specialist who ~~has completed the training under subdivision 5~~ is qualified according to section 245I.16, subdivision 12. A family peer specialist cannot provide services to the peer specialist's family.

Sec. 51. Minnesota Statutes 2018, section 256B.0616, subdivision 3, is amended to read:

Subd. 3. **Eligibility.** Family peer support services may be ~~located in~~ provided to recipients of inpatient hospitalization, partial hospitalization, residential treatment, intensive treatment in foster care, day treatment, children's therapeutic services and supports, or crisis services.

Sec. 52. Minnesota Statutes 2018, section 256B.0622, subdivision 1, is amended to read:

Subdivision 1. **Scope.** ~~Subject to federal approval,~~ Medical assistance covers medically necessary, assertive community treatment for clients as defined in subdivision 2a and intensive residential treatment services for clients as defined in subdivision 3, when the services are provided by an entity meeting the standards in this section.

Sec. 53. Minnesota Statutes 2018, section 256B.0622, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) For purposes of this section, the following terms have the meanings given them.

(b) "ACT team" means the group of interdisciplinary mental health staff who work as a team to provide assertive community treatment.

(c) "Assertive community treatment" means intensive nonresidential treatment and rehabilitative mental health services provided according to the assertive community treatment model. Assertive community treatment provides a single, fixed point of responsibility for

treatment, rehabilitation, and support needs for clients. Services are offered 24 hours per day, seven days per week, in a community-based setting.

~~(d) "Individual treatment plan" means the document that results from a person-centered planning process of determining real-life outcomes with clients and developing strategies to achieve those outcomes.~~

~~(e) "Assertive engagement" means the use of collaborative strategies to engage clients to receive services.~~

~~(f) "Benefits and finance support" means assisting clients in capably managing financial affairs. Services include, but are not limited to, assisting clients in applying for benefits; assisting with redetermination of benefits; providing financial crisis management; teaching and supporting budgeting skills and asset development; and coordinating with a client's representative payee, if applicable.~~

(d) "Clinical trainee" means a staff person qualified according to section 245I.16, subdivision 6.

~~(g)~~ (e) "Co-occurring disorder treatment" means the treatment of co-occurring mental illness and substance use disorders and is characterized by assertive outreach, stage-wise comprehensive treatment, treatment goal setting, and flexibility to work within each stage of treatment. Services include, but are not limited to, assessing and tracking clients' stages of change readiness and treatment; applying the appropriate treatment based on stages of change, such as outreach and motivational interviewing techniques to work with clients in earlier stages of change readiness and cognitive behavioral approaches and relapse prevention to work with clients in later stages of change; and facilitating access to community supports.

~~(h)~~ (f) "Crisis assessment and intervention" means mental health crisis response services as defined in section 256B.0624, subdivision 2, paragraphs (c) to (e).

~~(i) "Employment services" means assisting clients to work at jobs of their choosing. Services must follow the principles of the individual placement and support (IPS) employment model, including focusing on competitive employment; emphasizing individual client preferences and strengths; ensuring employment services are integrated with mental health services; conducting rapid job searches and systematic job development according to client preferences and choices; providing benefits counseling; and offering all services in an individualized and time-unlimited manner. Services shall also include educating clients about opportunities and benefits of work and school and assisting the client in learning job skills, navigating the work place, and managing work relationships.~~

~~(j) "Family psychoeducation and support" means services provided to the client's family and other natural supports to restore and strengthen the client's unique social and family relationships. Services include, but are not limited to, individualized psychoeducation about the client's illness and the role of the family and other significant people in the therapeutic process; family intervention to restore contact, resolve conflict, and maintain relationships with family and other significant people in the client's life; ongoing communication and collaboration between the ACT team and the family; introduction and referral to family self-help programs and advocacy organizations that promote recovery and family engagement, individual supportive counseling, parenting training, and service coordination to help clients fulfill parenting responsibilities; coordinating services for the child and restoring relationships with children who are not in the client's custody; and coordinating with child welfare and family agencies, if applicable. These services must be provided with the client's agreement and consent.~~

~~(k) "Housing access support" means assisting clients to find, obtain, retain, and move to safe and adequate housing of their choice. Housing access support includes, but is not limited to, locating housing options with a focus on integrated independent settings; applying for housing subsidies, programs, or resources; assisting the client in developing relationships with local landlords; providing tenancy support and advocacy for the individual's tenancy rights at the client's home; and assisting with relocation.~~

(g) "Individual treatment plan" means a plan described under section 256B.0671, subdivisions 5 and 6.

~~(l)~~ (h) "Individual treatment team" means a minimum of three members of the ACT team who are responsible for consistently carrying out most of a client's assertive community treatment services.

~~(m)~~ (i) "Intensive residential treatment services treatment team" means all staff who provide intensive residential treatment services under this section to clients. ~~At a minimum, this includes the clinical supervisor; mental health professionals as defined in section 245.462, subdivision 18, clauses (1) to (6); mental health practitioners as defined in section 245.462, subdivision 17; mental health rehabilitation workers under section 256B.0623, subdivision 5, paragraph (a), clause (4); and mental health certified peer specialists under section 256B.0615.~~

~~(n)~~ (j) "Intensive residential treatment services" means short-term, time-limited services provided in a residential setting to clients who are in need of more restrictive settings and are at risk of significant functional deterioration if they do not receive these services. Services

are designed to develop and enhance psychiatric stability, personal and emotional adjustment, self-sufficiency, and skills to live in a more independent setting. Services must be directed toward a targeted discharge date with specified client outcomes.

~~(o) "Medication assistance and support" means assisting clients in accessing medication, developing the ability to take medications with greater independence, and providing medication setup. This includes the prescription, administration, and order of medication by appropriate medical staff.~~

~~(p) "Medication education" means educating clients on the role and effects of medications in treating symptoms of mental illness and the side effects of medications.~~

(k) "Mental health certified peer specialist" means a staff person qualified according to section 245I.16, subdivision 10.

(l) "Mental health practitioner" means a staff person qualified according to section 245I.16, subdivision 4.

(m) "Mental health professional" means a staff person qualified according to section 245I.16, subdivision 2.

(n) "Mental health rehabilitation worker" means a staff person qualified according to section 245I.16, subdivision 14.

~~(q)~~ (o) "Overnight staff" means a member of the intensive residential treatment services team who is responsible during hours when clients are typically asleep.

~~(r) "Mental health certified peer specialist services" has the meaning given in section 256B.0615.~~

~~(s)~~ (p) "Physical health services" means any service or treatment to meet the physical health needs of the client to support the client's mental health recovery. Services include, but are not limited to, education on primary health issues, including wellness education; medication administration and monitoring; providing and coordinating medical screening and follow-up; scheduling routine and acute medical and dental care visits; tobacco cessation strategies; assisting clients in attending appointments; communicating with other providers; and integrating all physical and mental health treatment.

~~(t)~~ (q) "Primary team member" means the person who leads and coordinates the activities of the individual treatment team and is the individual treatment team member who has primary responsibility for establishing and maintaining a therapeutic relationship with the client on a continuing basis.

~~(u)~~ (r) "Rehabilitative mental health services" means mental health services that are rehabilitative and enable the client to develop and enhance psychiatric stability, social competencies, personal and emotional adjustment, independent living, parenting skills, and community skills, when these abilities are impaired by the symptoms of mental illness.

~~(v)~~ (s) "Symptom management" means supporting clients in identifying and targeting the symptoms and occurrence patterns of their mental illness and developing strategies to reduce the impact of those symptoms.

~~(w)~~ (t) "Therapeutic interventions" means empirically supported techniques to address specific symptoms and behaviors such as anxiety, psychotic symptoms, emotional dysregulation, and trauma symptoms. Interventions include empirically supported psychotherapies including, but not limited to, cognitive behavioral therapy, exposure therapy, acceptance and commitment therapy, interpersonal therapy, and motivational interviewing.

~~(x)~~ (u) "Wellness self-management and prevention" means a combination of approaches to working with the client to build and apply skills related to recovery, and to support the client in participating in leisure and recreational activities, civic participation, and meaningful structure.

Sec. 54. Minnesota Statutes 2018, section 256B.0622, subdivision 3a, is amended to read:

Subd. 3a. **Provider certification and contract requirements for assertive community treatment.** (a) The assertive community treatment provider must:

(1) have a contract with the host county to provide assertive community treatment services; and

(2) have each ACT team be certified by the state following the certification process and procedures developed by the commissioner. The certification process determines whether the ACT team meets the standards for assertive community treatment under this section ~~as well as~~, chapter 245I, and minimum program fidelity standards as measured by a nationally recognized fidelity tool approved by the commissioner. Recertification must occur at least every three years.

(b) An ACT team certified under this subdivision must meet the following standards:

(1) have capacity to recruit, hire, manage, and train required ACT team members;

(2) have adequate administrative ability to ensure availability of services;

~~(3) ensure adequate preservice and ongoing training for staff;~~

~~(4) ensure that staff is capable of implementing culturally specific services that are culturally responsive and appropriate as determined by the client's culture, beliefs, values, and language as identified in the individual treatment plan;~~

~~(5)~~ (3) ensure flexibility in service delivery to respond to the changing and intermittent care needs of a client as identified by the client and the individual treatment plan;

~~(6) develop and maintain client files, individual treatment plans, and contact charting;~~

~~(7) develop and maintain staff training and personnel files;~~

~~(8)~~ (4) submit information as required by the state;

~~(9)~~ (5) keep all necessary records required by law;

~~(10) comply with all applicable laws;~~

~~(11)~~ (6) be an enrolled Medicaid provider;

~~(12)~~ (7) establish and maintain a quality assurance plan to determine specific service outcomes and the client's satisfaction with services; and

~~(13)~~ (8) develop and maintain written policies and procedures regarding service provision and administration of the provider entity.

(c) The commissioner may intervene at any time and decertify an ACT team with cause. The commissioner shall establish a process for decertification of an ACT team and shall require corrective action, medical assistance repayment, or decertification of an ACT team that no longer meets the requirements in this section or that fails to meet the clinical quality standards or administrative standards provided by the commissioner in the application and certification process. The decertification is subject to appeal to the state.

Sec. 55. Minnesota Statutes 2018, section 256B.0622, subdivision 4, is amended to read:

Subd. 4. **Provider entity licensure and contract requirements for intensive residential treatment services.** (a) The intensive residential treatment services provider entity must:

(1) be licensed under Minnesota Rules, parts 9520.0500 to 9520.0670;

(2) not exceed 16 beds per site; and

(3) comply with the additional standards in this section and chapter 245I.

(b) The commissioner shall develop procedures for counties and providers to submit other documentation as needed to allow the commissioner to determine whether the standards in this section are met.

(c) A provider entity must specify in the provider entity's application what geographic area and populations will be served by the proposed program. A provider entity must document that the capacity or program specialties of existing programs are not sufficient to meet the service needs of the target population. A provider entity must submit evidence of ongoing relationships with other providers and levels of care to facilitate referrals to and from the proposed program.

(d) A provider entity must submit documentation that the provider entity requested a statement of need from each county board and tribal authority that serves as a local mental health authority in the proposed service area. The statement of need must specify if the local mental health authority supports or does not support the need for the proposed program and the basis for this determination. If a local mental health authority does not respond within 60 days of the receipt of the request, the commissioner shall determine the need for the program based on the documentation submitted by the provider entity.

Sec. 56. Minnesota Statutes 2018, section 256B.0622, subdivision 5a, is amended to read:

Subd. 5a. **Standards for intensive residential rehabilitative mental health services.** (a) The standards in this subdivision apply to intensive residential mental health services.

(b) The provider of intensive residential treatment services must have sufficient staff to provide 24-hour-per-day coverage to deliver the rehabilitative services described in the treatment plan and to safely supervise and direct the activities of clients, given the client's level of behavioral and psychiatric stability, cultural needs, and vulnerability. The provider must have the capacity within the facility to provide integrated services for chemical dependency, illness management services, and family education, when appropriate.

(c) At a minimum:

(1) staff must provide direction and supervision whenever clients are present in the facility;

(2) staff must remain awake during all work hours;

(3) there must be a staffing ratio of at least one to nine clients for each day and evening shift. If more than nine clients are present at the residential site, there must be a minimum of two staff during day and evening shifts, one of whom must be a mental health practitioner or mental health professional;

(4) if services are provided to clients who need the services of a medical professional, the provider shall ensure that these services are provided either by the provider's own medical staff or through referral to a medical professional; and

(5) the provider must ensure the timely availability of a licensed registered nurse, either directly employed or under contract, who is responsible for ensuring the effectiveness and safety of medication administration in the facility and assessing clients for medication side effects and drug interactions.

(d) Services must be provided by qualified staff as defined in section 256B.0623, subdivision 5~~, who are trained and supervised according to section 256B.0623, subdivision 6, except that mental health rehabilitation workers acting as overnight staff are not required to comply with section 256B.0623, subdivision 5, paragraph (a), clause (4), item (iv)~~.

(e) The ~~clinical~~ treatment supervisor must be an active member of the intensive residential services treatment team. The team must meet with the ~~clinical~~ treatment supervisor at least weekly to discuss clients' progress and make rapid adjustments to meet clients' needs. The team meeting shall include client-specific case reviews and general treatment discussions among team members. Client-specific case reviews and planning must be documented in the client's treatment record.

(f) Treatment staff must have prompt access in person or by telephone to a mental health practitioner or mental health professional. The provider must have the capacity to promptly and appropriately respond to emergent needs and make any necessary staffing adjustments to ensure the health and safety of clients.

(g) The initial functional assessment must be completed within ten days of intake and updated at least every 30 days, or prior to discharge from the service, whichever comes first.

(h) The initial individual treatment plan must be completed within 24 hours of admission. Within ten days of admission, the initial treatment plan must be refined and further developed, except for providers certified according to Minnesota Rules, parts 9533.0010 to 9533.0180. The individual treatment plan must be reviewed with the client and updated at least monthly.

Sec. 57. Minnesota Statutes 2018, section 256B.0622, subdivision 7, is amended to read:

Subd. 7. **Assertive community treatment service standards.** (a) ACT teams must offer and have the capacity to directly provide the following services:

(1) assertive engagement using collaborative strategies to encourage clients to receive services;

(2) benefits and finance support~~;~~ that assists clients to capably manage financial affairs. Services include but are not limited to assisting clients in applying for benefits, assisting with redetermination of benefits, providing financial crisis management, teaching and

supporting budgeting skills and asset development, and coordinating with a client's representative payee, if applicable;

(3) co-occurring disorder treatment;

(4) crisis assessment and intervention;

(5) employment services; that assists clients to work at jobs of their choosing. Services must follow the principles of the individual placement and support employment model, including focusing on competitive employment, emphasizing individual client preferences and strengths, ensuring employment services are integrated with mental health services, conducting rapid job searches and systematic job development according to client preferences and choices, providing benefits counseling, and offering all services in an individualized and time-unlimited manner. Services must also include educating clients about opportunities and benefits of work and school and assisting the client in learning job skills, navigating the workplace, and managing work relationships;

(6) family psychoeducation and support; provided to the client's family and other natural supports to restore and strengthen the client's unique social and family relationships. Services include but are not limited to individualized psychoeducation about the client's illness and the role of the family and other significant people in the therapeutic process; family intervention to restore contact, resolve conflict, and maintain relationships with family and other significant people in the client's life; ongoing communication and collaboration between the ACT team and the family; introduction and referral to family self-help programs and advocacy organizations that promote recovery and family engagement, individual supportive counseling, parenting training, and service coordination to help clients fulfill parenting responsibilities; coordinating services for the child and restoring relationships with children who are not in the client's custody; and coordinating with child welfare and family agencies, if applicable. These services must be provided with the client's agreement and consent;

(7) housing access support; that assists clients to find, obtain, retain, and move to safe and adequate housing of their choice. Housing access support includes but is not limited to locating housing options with a focus on integrated independent settings; applying for housing subsidies, programs, or resources; assisting the client in developing relationships with local landlords; providing tenancy support and advocacy for the individual's tenancy rights at the client's home; and assisting with relocation;

(8) medication assistance and support; that assists clients in accessing medication, developing the ability to take medications with greater independence, and providing

medication setup. Medication assistance and support includes assisting the client with the prescription, administration, and ordering of medication by appropriate medical staff;

(9) medication education~~;~~ that educates clients on the role and effects of medications in treating symptoms of mental illness and the side effects of medications;

(10) mental health certified peer specialists services;

(11) physical health services;

(12) rehabilitative mental health services;

(13) symptom management;

(14) therapeutic interventions;

(15) wellness self-management and prevention; and

(16) other services based on client needs as identified in a client's assertive community treatment individual treatment plan.

(b) ACT teams must ensure the provision of all services necessary to meet a client's needs as identified in the client's individual treatment plan.

Sec. 58. Minnesota Statutes 2018, section 256B.0622, subdivision 7a, is amended to read:

Subd. 7a. **Assertive community treatment team staff requirements and roles.** (a) The required treatment staff qualifications and roles for an ACT team are:

(1) the team leader:

(i) shall be a ~~licensed~~ mental health professional ~~who is qualified under Minnesota Rules, part 9505.0371, subpart 5, item A~~. Individuals who are not licensed but who are eligible for licensure and are otherwise qualified may also fulfill this role but must obtain full licensure within 24 months of assuming the role of team leader;

(ii) must be an active member of the ACT team and provide some direct services to clients;

(iii) must be a single full-time staff member, dedicated to the ACT team, who is responsible for overseeing the administrative operations of the team, providing ~~clinical oversight~~ treatment supervision of services in conjunction with the psychiatrist or psychiatric care provider, and supervising team members to ensure delivery of best and ethical practices; and

(iv) must be available to provide overall ~~clinical oversight~~ treatment supervision to the ACT team after regular business hours and on weekends and holidays. The team leader may delegate this duty to another qualified member of the ACT team;

(2) the psychiatric care provider:

(i) must be a ~~licensed psychiatrist certified by the American Board of Psychiatry and Neurology or eligible for board certification or certified by the American Osteopathic Board of Neurology and Psychiatry or eligible for board certification, or a psychiatric nurse who is qualified under Minnesota Rules, part 9505.0371, subpart 5, item A~~ mental health professional. The psychiatric care provider must have demonstrated clinical experience working with individuals with serious and persistent mental illness;

(ii) shall collaborate with the team leader in sharing overall clinical responsibility for screening and admitting clients; monitoring clients' treatment and team member service delivery; educating staff on psychiatric and nonpsychiatric medications, their side effects, and health-related conditions; actively collaborating with nurses; and helping provide ~~clinical~~ treatment supervision to the team;

(iii) shall fulfill the following functions for assertive community treatment clients: provide assessment and treatment of clients' symptoms and response to medications, including side effects; provide brief therapy to clients; provide diagnostic and medication education to clients, with medication decisions based on shared decision making; monitor clients' nonpsychiatric medical conditions and nonpsychiatric medications; and conduct home and community visits;

(iv) shall serve as the point of contact for psychiatric treatment if a client is hospitalized for mental health treatment and shall communicate directly with the client's inpatient psychiatric care providers to ensure continuity of care;

(v) shall have a minimum full-time equivalency that is prorated at a rate of 16 hours per 50 clients. Part-time psychiatric care providers shall have designated hours to work on the team, with sufficient blocks of time on consistent days to carry out the provider's clinical, supervisory, and administrative responsibilities. No more than two psychiatric care providers may share this role;

(vi) may not provide specific roles and responsibilities by telemedicine unless approved by the commissioner; and

(vii) shall provide psychiatric backup to the program after regular business hours and on weekends and holidays. The psychiatric care provider may delegate this duty to another qualified psychiatric provider;

(3) the nursing staff:

(i) shall consist of one to three registered nurses or advanced practice registered nurses, of whom at least one has a minimum of one-year experience working with adults with serious mental illness and a working knowledge of psychiatric medications. No more than two individuals can share a full-time equivalent position;

(ii) are responsible for managing medication, administering and documenting medication treatment, and managing a secure medication room; and

(iii) shall develop strategies, in collaboration with clients, to maximize taking medications as prescribed; screen and monitor clients' mental and physical health conditions and medication side effects; engage in health promotion, prevention, and education activities; communicate and coordinate services with other medical providers; facilitate the development of the individual treatment plan for clients assigned; and educate the ACT team in monitoring psychiatric and physical health symptoms and medication side effects;

(4) the co-occurring disorder specialist:

(i) shall be a full-time equivalent co-occurring disorder specialist who has received specific training on co-occurring disorders that is consistent with national evidence-based practices. The training must include practical knowledge of common substances and how they affect mental illnesses, the ability to assess substance use disorders and the client's stage of treatment, motivational interviewing, and skills necessary to provide counseling to clients at all different stages of change and treatment. The co-occurring disorder specialist may also be an individual who is a licensed alcohol and drug counselor as described in section 148F.01, subdivision 5, or a counselor who otherwise meets the training, experience, and other requirements in section 245G.11, subdivision 5. No more than two co-occurring disorder specialists may occupy this role; and

(ii) shall provide or facilitate the provision of co-occurring disorder treatment to clients. The co-occurring disorder specialist shall serve as a consultant and educator to fellow ACT team members on co-occurring disorders;

(5) the vocational specialist:

(i) shall be a full-time vocational specialist who has at least one-year experience providing employment services or advanced education that involved field training in vocational services

to individuals with mental illness. An individual who does not meet these qualifications may also serve as the vocational specialist upon completing a training plan approved by the commissioner;

(ii) shall provide or facilitate the provision of vocational services to clients. The vocational specialist serves as a consultant and educator to fellow ACT team members on these services; and

(iii) ~~should~~ shall not refer individuals to receive any type of vocational services or linkage by providers outside of the ACT team;

(6) the mental health certified peer specialist:

(i) shall be a full-time equivalent ~~mental health certified peer specialist as defined in section 256B.0615~~. No more than two individuals can share this position. The mental health certified peer specialist is a fully integrated team member who provides highly individualized services in the community and promotes the self-determination and shared decision-making abilities of clients. This requirement may be waived due to workforce shortages upon approval of the commissioner;

(ii) must provide coaching, mentoring, and consultation to the clients to promote recovery, self-advocacy, and self-direction, promote wellness management strategies, and assist clients in developing advance directives; and

(iii) must model recovery values, attitudes, beliefs, and personal action to encourage wellness and resilience, provide consultation to team members, promote a culture where the clients' points of view and preferences are recognized, understood, respected, and integrated into treatment, and serve in a manner equivalent to other team members;

(7) the program administrative assistant shall be a full-time office-based program administrative assistant position assigned to solely work with the ACT team, providing a range of supports to the team, clients, and families; and

(8) additional staff:

(i) shall be based on team size. Additional treatment team staff may include ~~licensed~~ mental health professionals ~~as defined in Minnesota Rules, part 9505.0371, subpart 5, item A~~; mental health practitioners ~~as defined in section 245.462, subdivision 17; a mental health practitioner working as a~~; clinical ~~trainee according to Minnesota Rules, part 9505.0371, subpart 5, item C~~ trainees; or mental health rehabilitation workers ~~as defined in section 256B.0623, subdivision 5, paragraph (a), clause (4)~~. These individuals shall have the

knowledge, skills, and abilities required by the population served to carry out rehabilitation and support functions; and

(ii) shall be selected based on specific program needs or the population served.

(b) Each ACT team must clearly document schedules for all ACT team members.

(c) Each ACT team member must serve as a primary team member for clients assigned by the team leader and are responsible for facilitating the individual treatment plan process for those clients. The primary team member for a client is the responsible team member knowledgeable about the client's life and circumstances and writes the individual treatment plan. The primary team member provides individual supportive therapy or counseling, and provides primary support and education to the client's family and support system.

(d) Members of the ACT team must have strong clinical skills, professional qualifications, experience, and competency to provide a full breadth of rehabilitation services. Each staff member shall be proficient in their respective discipline and be able to work collaboratively as a member of a multidisciplinary team to deliver the majority of the treatment, rehabilitation, and support services clients require to fully benefit from receiving assertive community treatment.

(e) Each ACT team member must fulfill training requirements established by the commissioner.

Sec. 59. Minnesota Statutes 2018, section 256B.0622, subdivision 7b, is amended to read:

Subd. 7b. **Assertive community treatment program size and opportunities.** (a) Each ACT team shall maintain an annual average caseload that does not exceed 100 clients. Staff-to-client ratios shall be based on team size as follows:

(1) a small ACT team must:

(i) employ at least six but no more than seven full-time treatment team staff, excluding the program assistant and the psychiatric care provider;

(ii) serve an annual average maximum of no more than 50 clients;

(iii) ensure at least one full-time equivalent position for every eight clients served;

(iv) schedule ACT team staff for at least eight-hour shift coverage on weekdays and on-call duty to provide crisis services and deliver services after hours when staff are not working;

(v) provide crisis services during business hours if the small ACT team does not have sufficient staff numbers to operate an after-hours on-call system. During all other hours, the ACT team may arrange for coverage for crisis assessment and intervention services through a reliable crisis-intervention provider as long as there is a mechanism by which the ACT team communicates routinely with the crisis-intervention provider and the on-call ACT team staff are available to see clients face-to-face when necessary or if requested by the crisis-intervention services provider;

(vi) adjust schedules and provide staff to carry out the needed service activities in the evenings or on weekend days or holidays, when necessary;

(vii) arrange for and provide psychiatric backup during all hours the psychiatric care provider is not regularly scheduled to work. If availability of the ACT team's psychiatric care provider during all hours is not feasible, alternative psychiatric prescriber backup must be arranged and a mechanism of timely communication and coordination established in writing; and

(viii) be composed of, at minimum, one full-time team leader, at least 16 hours each week per 50 clients of psychiatric provider time, or equivalent if fewer clients, one full-time equivalent nursing, one full-time substance abuse specialist, one full-time equivalent mental health certified peer specialist, one full-time vocational specialist, one full-time program assistant, and at least one additional full-time ACT team member who has mental health professional, clinical trainee, or mental health practitioner status; and

(2) a midsize ACT team shall:

(i) be composed of, at minimum, one full-time team leader, at least 16 hours of psychiatry time for 51 clients, with an additional two hours for every six clients added to the team, 1.5 to two full-time equivalent nursing staff, one full-time substance abuse specialist, one full-time equivalent mental health certified peer specialist, one full-time vocational specialist, one full-time program assistant, and at least 1.5 to two additional full-time equivalent ACT members, with at least one dedicated full-time staff member with mental health professional status. Remaining team members may have mental health professional, clinical trainee, or mental health practitioner status;

(ii) employ seven or more treatment team full-time equivalents, excluding the program assistant and the psychiatric care provider;

(iii) serve an annual average maximum caseload of 51 to 74 clients;

(iv) ensure at least one full-time equivalent position for every nine clients served;

(v) schedule ACT team staff for a minimum of ten-hour shift coverage on weekdays and six- to eight-hour shift coverage on weekends and holidays. In addition to these minimum specifications, staff are regularly scheduled to provide the necessary services on a client-by-client basis in the evenings and on weekends and holidays;

(vi) schedule ACT team staff on-call duty to provide crisis services and deliver services when staff are not working;

(vii) have the authority to arrange for coverage for crisis assessment and intervention services through a reliable crisis-intervention provider as long as there is a mechanism by which the ACT team communicates routinely with the crisis-intervention provider and the on-call ACT team staff are available to see clients face-to-face when necessary or if requested by the crisis-intervention services provider; and

(viii) arrange for and provide psychiatric backup during all hours the psychiatric care provider is not regularly scheduled to work. If availability of the psychiatric care provider during all hours is not feasible, alternative psychiatric prescriber backup must be arranged and a mechanism of timely communication and coordination established in writing;

(3) a large ACT team must:

(i) be composed of, at minimum, one full-time team leader, at least 32 hours each week per 100 clients, or equivalent of psychiatry time, three full-time equivalent nursing staff, one full-time substance abuse specialist, one full-time equivalent mental health certified peer specialist, one full-time vocational specialist, one full-time program assistant, and at least two additional full-time equivalent ACT team members, with at least one dedicated full-time staff member with mental health professional status. Remaining team members may have mental health professional, clinical trainee, or mental health practitioner status;

(ii) employ nine or more treatment team full-time equivalents, excluding the program assistant and psychiatric care provider;

(iii) serve an annual average maximum caseload of 75 to 100 clients;

(iv) ensure at least one full-time equivalent position for every nine individuals served;

(v) schedule staff to work two eight-hour shifts, with a minimum of two staff on the second shift providing services at least 12 hours per day weekdays. For weekends and holidays, the team must operate and schedule ACT team staff to work one eight-hour shift, with a minimum of two staff each weekend day and every holiday;

(vi) schedule ACT team staff on-call duty to provide crisis services and deliver services when staff are not working; and

(vii) arrange for and provide psychiatric backup during all hours the psychiatric care provider is not regularly scheduled to work. If availability of the ACT team psychiatric care provider during all hours is not feasible, alternative psychiatric backup must be arranged and a mechanism of timely communication and coordination established in writing.

(b) An ACT team of any size may have a staff-to-client ratio that is lower than the requirements described in paragraph (a) upon approval by the commissioner, but may not exceed a one-to-ten staff-to-client ratio.

Sec. 60. Minnesota Statutes 2018, section 256B.0622, subdivision 7d, is amended to read:

Subd. 7d. **Assertive community treatment assessment and individual treatment plan.** (a) An initial assessment, including a diagnostic assessment that meets the requirements of ~~Minnesota Rules, part 9505.0372, subpart 1,~~ section 256B.0671, subdivisions 2 and 3, and a 30-day treatment plan shall be completed the day of the client's admission to assertive community treatment by the ACT team leader or the psychiatric care provider, with participation by designated ACT team members and the client. The team leader, psychiatric care provider, or other mental health professional designated by the team leader or psychiatric care provider, must update the client's diagnostic assessment at least annually.

(b) An initial functional assessment must be completed within ten days of intake and updated every six months for assertive community treatment, or prior to discharge from the service, whichever comes first.

(c) Within 30 days of the client's assertive community treatment admission, the ACT team shall complete an in-depth assessment of the domains listed under section 245.462, subdivision 11a.

(d) Each part of the in-depth assessment areas shall be completed by each respective team specialist or an ACT team member with skill and knowledge in the area being assessed. The assessments are based upon all available information, including that from client interview family and identified natural supports, and written summaries from other agencies, including police, courts, county social service agencies, outpatient facilities, and inpatient facilities, where applicable.

(e) Between 30 and 45 days after the client's admission to assertive community treatment, the entire ACT team must hold a comprehensive case conference, where all team members, including the psychiatric provider, present information discovered from the completed in-depth assessments and provide treatment recommendations. The conference must serve

as the basis for the first six-month treatment plan, which must be written by the primary team member.

(f) The client's psychiatric care provider, primary team member, and individual treatment team members shall assume responsibility for preparing the written narrative of the results from the psychiatric and social functioning history timeline and the comprehensive assessment.

(g) The primary team member and individual treatment team members shall be assigned by the team leader in collaboration with the psychiatric care provider by the time of the first treatment planning meeting or 30 days after admission, whichever occurs first.

(h) Individual treatment plans must be developed through the following treatment planning process:

(1) The individual treatment plan shall be developed in collaboration with the client and the client's preferred natural supports, and guardian, if applicable and appropriate. The ACT team shall evaluate, together with each client, the client's needs, strengths, and preferences and develop the individual treatment plan collaboratively. The ACT team shall make every effort to ensure that the client and the client's family and natural supports, with the client's consent, are in attendance at the treatment planning meeting, are involved in ongoing meetings related to treatment, and have the necessary supports to fully participate. The client's participation in the development of the individual treatment plan shall be documented.

(2) The client and the ACT team shall work together to formulate and prioritize the issues, set goals, research approaches and interventions, and establish the plan. The plan is individually tailored so that the treatment, rehabilitation, and support approaches and interventions achieve optimum symptom reduction, help fulfill the personal needs and aspirations of the client, take into account the cultural beliefs and realities of the individual, and improve all the aspects of psychosocial functioning that are important to the client. The process supports strengths, rehabilitation, and recovery.

(3) Each client's individual treatment plan shall identify service needs, strengths and capacities, and barriers, and set specific and measurable short- and long-term goals for each service need. The individual treatment plan must clearly specify the approaches and interventions necessary for the client to achieve the individual goals, when the interventions shall happen, and identify which ACT team member shall carry out the approaches and interventions.

(4) The primary team member and the individual treatment team, together with the client and the client's family and natural supports with the client's consent, are responsible for

reviewing and rewriting the treatment goals and individual treatment plan whenever there is a major decision point in the client's course of treatment or at least every six months.

(5) The primary team member shall prepare a summary that thoroughly describes in writing the client's and the individual treatment team's evaluation of the client's progress and goal attainment, the effectiveness of the interventions, and the satisfaction with services since the last individual treatment plan. The client's most recent diagnostic assessment must be included with the treatment plan summary.

(6) The individual treatment plan and review must be ~~signed~~ approved or acknowledged by the client, the primary team member, the team leader, the psychiatric care provider, and all individual treatment team members. A copy of the ~~signed~~ individual treatment plan is made available to the client.

Sec. 61. Minnesota Statutes 2018, section 256B.0623, subdivision 1, is amended to read:

Subdivision 1. **Scope.** Medical assistance covers adult rehabilitative mental health services as defined in subdivision 2, ~~subject to federal approval,~~ if provided to recipients as defined in subdivision 3 and provided by a qualified provider entity meeting the standards in this section and by a qualified individual provider working within the provider's scope of practice and identified in the recipient's individual treatment plan ~~as defined~~ described in section ~~245.462, subdivision 14~~ 256B.0671, subdivisions 5 and 6, and if determined to be medically necessary according to section 62Q.53.

Sec. 62. Minnesota Statutes 2018, section 256B.0623, subdivision 2, is amended to read:

Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings given them.

(a) "Adult rehabilitative mental health services" means mental health services which are rehabilitative and enable the recipient to develop and enhance psychiatric stability, social competencies, personal and emotional adjustment, independent living, parenting skills, and community skills, when these abilities are impaired by the symptoms of mental illness. ~~Adult rehabilitative mental health services are also appropriate when provided to enable a recipient to retain stability and functioning, if the recipient would be at risk of significant functional decompensation or more restrictive service settings without these services.~~

~~(1) Adult rehabilitative mental health services instruct, assist, and support the recipient in areas such as: interpersonal communication skills, community resource utilization and integration skills, crisis assistance, relapse prevention skills, health care directives, budgeting~~

~~and shopping skills, healthy lifestyle skills and practices, cooking and nutrition skills, transportation skills, medication education and monitoring, mental illness symptom management skills, household management skills, employment-related skills, parenting skills, and transition to community living services.~~

~~(2) These services shall be provided to the recipient on a one-to-one basis in the recipient's home or another community setting or in groups.~~

(b) "Medication education services" means services provided individually or in groups which focus on educating the recipient about mental illness and symptoms; the role and effects of medications in treating symptoms of mental illness; and the side effects of medications. Medication education is coordinated with medication management services and does not duplicate it. Medication education services are provided by physicians, pharmacists, physician assistants, or registered nurses.

(c) "Transition to community living services" means services which maintain continuity of contact between the rehabilitation services provider and the recipient and which facilitate discharge from a hospital, residential treatment program under Minnesota Rules, chapter 9505, board and lodging facility, or nursing home. Transition to community living services are not intended to provide other areas of adult rehabilitative mental health services.

Sec. 63. Minnesota Statutes 2018, section 256B.0623, subdivision 3, is amended to read:

Subd. 3. **Eligibility.** An eligible recipient is an individual who:

(1) is age 18 or older;

(2) is diagnosed with a medical condition, such as mental illness or traumatic brain injury, for which adult rehabilitative mental health services are needed;

(3) has substantial disability and functional impairment in three or more of the areas listed in section 245.462, subdivision 11a, so that self-sufficiency is markedly reduced; and

(4) has had a recent diagnostic assessment ~~or an adult diagnostic assessment update~~ by a qualified professional that documents adult rehabilitative mental health services are medically necessary to address identified disability and functional impairments and individual recipient goals.

Sec. 64. Minnesota Statutes 2018, section 256B.0623, subdivision 4, is amended to read:

Subd. 4. **Provider entity standards.** (a) The provider entity must be certified by the state following the certification process and procedures developed by the commissioner.

(b) The certification process is a determination as to whether the entity meets the standards in this subdivision and chapter 245I. The certification must specify which adult rehabilitative mental health services the entity is qualified to provide.

(c) A noncounty provider entity must obtain additional certification from each county in which it will provide services. The additional certification must be based on the adequacy of the entity's knowledge of that county's local health and human service system, and the ability of the entity to coordinate its services with the other services available in that county. A county-operated entity must obtain this additional certification from any other county in which it will provide services.

(d) State-level recertification must occur at least every three years.

(e) The commissioner may intervene at any time and decertify providers with cause. The decertification is subject to appeal to the state. A county board may recommend that the state decertify a provider for cause.

(f) The adult rehabilitative mental health services provider entity must meet the following standards:

(1) have capacity to recruit, hire, manage, and train ~~mental health professionals, mental health practitioners, and mental health rehabilitation workers~~ qualified staff;

(2) have adequate administrative ability to ensure availability of services;

~~(3) ensure adequate preservice and inservice and ongoing training for staff;~~

~~(4)~~ (3) ensure that ~~mental health professionals, mental health practitioners, and mental health rehabilitation workers~~ staff are skilled in the delivery of the specific adult rehabilitative mental health services provided to the individual eligible recipient;

~~(5) ensure that staff is capable of implementing culturally specific services that are culturally competent and appropriate as determined by the recipient's culture, beliefs, values, and language as identified in the individual treatment plan;~~

~~(6)~~ (4) ensure enough flexibility in service delivery to respond to the changing and intermittent care needs of a recipient as identified by the recipient and the individual treatment plan;

~~(7) ensure that the mental health professional or mental health practitioner, who is under the clinical supervision of a mental health professional, involved in a recipient's services participates in the development of the individual treatment plan;~~

~~(8)~~ (5) assist the recipient in arranging needed crisis assessment, intervention, and stabilization services;

~~(9)~~ (6) ensure that services are coordinated with other recipient mental health services providers and the county mental health authority and the federally recognized American Indian authority and necessary others after obtaining the consent of the recipient. Services must also be coordinated with the recipient's case manager or care coordinator if the recipient is receiving case management or care coordination services;

~~(10) develop and maintain recipient files, individual treatment plans, and contact charting;~~

~~(11) develop and maintain staff training and personnel files;~~

~~(12)~~ (7) submit information as required by the state;

~~(13) establish and maintain a quality assurance plan to evaluate the outcome of services provided;~~

~~(14)~~ (8) keep all necessary records required by law;

~~(15)~~ (9) deliver services as required by section 245.461;

~~(16) comply with all applicable laws;~~

~~(17)~~ (10) be an enrolled Medicaid provider;

~~(18)~~ (11) maintain a quality assurance plan to determine specific service outcomes and the recipient's satisfaction with services; and

~~(19)~~ (12) develop and maintain written policies and procedures regarding service provision and administration of the provider entity.

Sec. 65. Minnesota Statutes 2018, section 256B.0623, subdivision 5, is amended to read:

Subd. 5. **Qualifications of provider staff.** ~~(a)~~ Adult rehabilitative mental health services must be provided by qualified individual provider staff of a certified provider entity. Individual provider staff must be qualified ~~under~~ as one of the following ~~criteria~~ providers:

(1) a mental health professional ~~as defined in section 245.462, subdivision 18, clauses (1) to (6). If the recipient has a current diagnostic assessment by a licensed mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6), recommending receipt of adult mental health rehabilitative services, the definition of mental health professional for purposes of this section includes a person who is qualified under section 245.462, subdivision 18, clause (7), and who holds a current and valid national certification~~

~~as a certified rehabilitation counselor or certified psychosocial rehabilitation practitioner~~ qualified according to section 245I.16, subdivision 2;

(2) a certified rehabilitation specialist qualified according to section 245I.16, subdivision 8;

(3) a clinical trainee qualified according to section 245I.16, subdivision 6;

~~(2)~~ (4) a mental health practitioner ~~as defined in section 245.462, subdivision 17. The mental health practitioner must work under the clinical supervision of a mental health professional~~ qualified according to section 245I.16, subdivision 4;

~~(3)~~ (5) a mental health certified peer specialist ~~under section 256B.0615. The certified peer specialist must work under the clinical supervision of a mental health professional~~ qualified according to section 245I.16, subdivision 10; or

~~(4)~~ (6) a mental health rehabilitation worker qualified according to section 245I.16, subdivision 14. ~~A mental health rehabilitation worker means a staff person working under the direction of a mental health practitioner or mental health professional and under the clinical supervision of a mental health professional in the implementation of rehabilitative mental health services as identified in the recipient's individual treatment plan who:~~

~~(i) is at least 21 years of age;~~

~~(ii) has a high school diploma or equivalent;~~

~~(iii) has successfully completed 30 hours of training during the two years immediately prior to the date of hire, or before provision of direct services, in all of the following areas: recovery from mental illness, mental health de-escalation techniques, recipient rights, recipient-centered individual treatment planning, behavioral terminology, mental illness, co-occurring mental illness and substance abuse, psychotropic medications and side effects, functional assessment, local community resources, adult vulnerability, recipient confidentiality; and~~

~~(iv) meets the qualifications in paragraph (b).~~

~~(b) In addition to the requirements in paragraph (a), a mental health rehabilitation worker must also meet the qualifications in clause (1), (2), or (3):~~

~~(1) has an associates of arts degree, two years of full-time postsecondary education, or a total of 15 semester hours or 23 quarter hours in behavioral sciences or related fields; is a registered nurse; or within the previous ten years has:~~

~~(i) three years of personal life experience with serious mental illness;~~

~~(ii) three years of life experience as a primary caregiver to an adult with a serious mental illness, traumatic brain injury, substance use disorder, or developmental disability; or~~

~~(iii) 2,000 hours of supervised work experience in the delivery of mental health services to adults with a serious mental illness, traumatic brain injury, substance use disorder, or developmental disability;~~

~~(2)(i) is fluent in the non-English language or competent in the culture of the ethnic group to which at least 20 percent of the mental health rehabilitation worker's clients belong;~~

~~(ii) receives during the first 2,000 hours of work, monthly documented individual clinical supervision by a mental health professional;~~

~~(iii) has 18 hours of documented field supervision by a mental health professional or mental health practitioner during the first 160 hours of contact work with recipients, and at least six hours of field supervision quarterly during the following year;~~

~~(iv) has review and cosignature of charting of recipient contacts during field supervision by a mental health professional or mental health practitioner; and~~

~~(v) has 15 hours of additional continuing education on mental health topics during the first year of employment and 15 hours during every additional year of employment; or~~

~~(3) for providers of crisis residential services, intensive residential treatment services, partial hospitalization, and day treatment services:~~

~~(i) satisfies clause (2), items (ii) to (iv); and~~

~~(ii) has 40 hours of additional continuing education on mental health topics during the first year of employment.~~

~~(c) A mental health rehabilitation worker who solely acts and is scheduled as overnight staff is not required to comply with paragraph (a), clause (4), item (iv).~~

~~(d) For purposes of this subdivision, "behavioral sciences or related fields" means an education from an accredited college or university and includes but is not limited to social work, psychology, sociology, community counseling, family social science, child development, child psychology, community mental health, addiction counseling, counseling and guidance, special education, and other fields as approved by the commissioner.~~

Sec. 66. Minnesota Statutes 2018, section 256B.0623, subdivision 6, is amended to read:

Subd. 6. **Required training and supervision.** (a) ~~Mental health rehabilitation workers must receive ongoing continuing education training of at least 30 hours every two years in~~

~~areas of mental illness and mental health services and other areas specific to the population being served. Mental health rehabilitation workers must also be subject to the ongoing direction and clinical supervision standards in paragraphs (c) and (d)~~ Staff must receive training in accordance with section 245I.10.

~~(b) Mental health practitioners must receive ongoing continuing education training as required by their professional license; or if the practitioner is not licensed, the practitioner must receive ongoing continuing education training of at least 30 hours every two years in areas of mental illness and mental health services. Mental health practitioners must meet the ongoing clinical supervision standards in paragraph (c).~~

~~(c) Clinical supervision may be provided by a full- or part-time qualified professional employed by or under contract with the provider entity. Clinical supervision may be provided by interactive videoconferencing according to procedures developed by the commissioner.~~ (b) Treatment supervision must be provided according to section 245I.18. A mental health professional providing ~~clinical~~ treatment supervision of staff delivering adult rehabilitative mental health services must provide the following guidance:

~~(1) review the information in the recipient's file;~~

~~(2) review and approve initial and updates of individual treatment plans;~~

~~(3)~~ (1) meet with ~~mental health rehabilitation workers and practitioners, individually or in small groups,~~ staff receiving direction at least monthly to discuss treatment topics of interest ~~to the workers and practitioners~~;

~~(4) meet with mental health rehabilitation workers and practitioners, individually or in small groups, at least monthly to~~ (2) discuss treatment plans of recipients~~, and approve by signature and document in the recipient's file any resulting plan updates~~;

~~(5) meet at least monthly with the directing mental health practitioner, if there is one, to~~ (3) review needs of the adult rehabilitative mental health services program, review staff on-site observations and evaluate mental health rehabilitation workers, plan staff training, and review program evaluation and development~~, and consult with the directing practitioner; and~~;

~~(6) be available for urgent consultation as the individual recipient needs or the situation necessitates.~~

~~(d) An adult rehabilitative mental health services provider entity must have a treatment director who is a mental health practitioner or mental health professional. The treatment director must ensure the following:~~

~~(1) while delivering direct services to recipients, a newly hired mental health rehabilitation worker must be directly observed delivering services to recipients by a mental health practitioner or mental health professional for at least six hours per 40 hours worked during the first 160 hours that the mental health rehabilitation worker works;~~

~~(2) the mental health rehabilitation worker must receive ongoing on-site direct service observation by a mental health professional or mental health practitioner for at least six hours for every six months of employment;~~

~~(3)~~ (4) review progress notes ~~are reviewed~~ from on-site service observation prepared by the mental health rehabilitation worker and mental health practitioner for accuracy and consistency with actual recipient contact and the individual treatment plan and goals;

~~(4)~~ (5) ensure immediate availability by phone or in person for consultation by a mental health professional or a mental health practitioner to the mental health rehabilitation services worker during service provision; and

~~(5) oversee the identification of changes in individual recipient treatment strategies, revise the plan, and communicate treatment instructions and methodologies as appropriate to ensure that treatment is implemented correctly;~~

~~(6) model service practices which: respect the recipient, include the recipient in planning and implementation of the individual treatment plan, recognize the recipient's strengths, collaborate and coordinate with other involved parties and providers;~~

~~(7)~~ (6) ensure that mental health practitioners and mental health rehabilitation workers are able to effectively communicate with the recipients, significant others, and providers~~; and~~.

~~(8) oversee the record of the results of on-site observation and charting evaluation and corrective actions taken to modify the work of the mental health practitioners and mental health rehabilitation workers.~~

~~(c) A mental health practitioner who is providing treatment direction for a provider entity must receive supervision at least monthly from a mental health professional to:~~

~~(1) identify and plan for general needs of the recipient population served;~~

~~(2) identify and plan to address provider entity program needs and effectiveness;~~

~~(3) identify and plan provider entity staff training and personnel needs and issues; and~~

~~(4) plan, implement, and evaluate provider entity quality improvement programs.~~

Sec. 67. Minnesota Statutes 2018, section 256B.0623, subdivision 7, is amended to read:

Subd. 7. **Personnel file.** The adult rehabilitative mental health services provider entity must maintain a personnel file on each staff in accordance with section 245I.13. ~~Each file must contain:~~

~~(1) an annual performance review;~~

~~(2) a summary of on-site service observations and charting review;~~

~~(3) a criminal background check of all direct service staff;~~

~~(4) evidence of academic degree and qualifications;~~

~~(5) a copy of professional license;~~

~~(6) any job performance recognition and disciplinary actions;~~

~~(7) any individual staff written input into own personnel file;~~

~~(8) all clinical supervision provided; and~~

~~(9) documentation of compliance with continuing education requirements.~~

Sec. 68. Minnesota Statutes 2018, section 256B.0623, subdivision 8, is amended to read:

Subd. 8. **Diagnostic assessment.** Providers of adult rehabilitative mental health services must obtain or complete a diagnostic assessment ~~as defined in~~ according to section ~~245.462, subdivision 9, within five days after the recipient's second visit or within 30 days after intake, whichever occurs first. In cases where a diagnostic assessment is available that reflects the recipient's current status, and has been completed within three years preceding admission, an adult diagnostic assessment update must be completed. An update shall include a face-to-face interview with the recipient and a written summary by a mental health professional of the recipient's current mental health status and service needs. If the recipient's mental health status has changed significantly since the adult's most recent diagnostic assessment, a new diagnostic assessment is required~~ 256B.0671, subdivisions 2 and 3.

Sec. 69. Minnesota Statutes 2018, section 256B.0623, subdivision 10, is amended to read:

Subd. 10. **Individual treatment plan.** All providers of adult rehabilitative mental health services must develop and implement an individual treatment plan for each recipient. ~~The provisions in clauses (1) and (2) apply:~~ according to section 256B.0671, subdivisions 5 and 6.

~~(1) Individual treatment plan means a plan of intervention, treatment, and services for an individual recipient written by a mental health professional or by a mental health practitioner under the clinical supervision of a mental health professional. The individual treatment plan must be based on diagnostic and functional assessments. To the extent possible, the development and implementation of a treatment plan must be a collaborative process involving the recipient, and with the permission of the recipient, the recipient's family and others in the recipient's support system. Providers of adult rehabilitative mental health services must develop the individual treatment plan within 30 calendar days of intake.~~ The treatment plan must be updated at least every six months thereafter, or more often when there is significant change in the recipient's situation or functioning, or in services or service methods to be used, or at the request of the recipient or the recipient's legal guardian.

~~(2) The individual treatment plan must include:~~

~~(i) a list of problems identified in the assessment;~~

~~(ii) the recipient's strengths and resources;~~

~~(iii) concrete, measurable goals to be achieved, including time frames for achievement;~~

~~(iv) specific objectives directed toward the achievement of each one of the goals;~~

~~(v) documentation of participants in the treatment planning. The recipient, if possible, must be a participant. The recipient or the recipient's legal guardian must sign the treatment plan, or documentation must be provided why this was not possible. A copy of the plan must be given to the recipient or legal guardian. Referral to formal services must be arranged, including specific providers where applicable;~~

~~(vi) cultural considerations, resources, and needs of the recipient must be included;~~

~~(vii) planned frequency and type of services must be initiated; and~~

~~(viii) clear progress notes on outcome of goals.~~

~~(3) The individual community support plan defined in section 245.462, subdivision 12, may serve as the individual treatment plan if there is involvement of a mental health case manager, and with the approval of the recipient. The individual community support plan must include the criteria in clause (2).~~

Sec. 70. Minnesota Statutes 2018, section 256B.0623, subdivision 11, is amended to read:

Subd. 11. **Recipient file.** Providers of adult rehabilitative mental health services must maintain a file for each recipient ~~that contains the following information:~~ according to section 245I.32.

~~(1) diagnostic assessment or verification of its location that is current and that was reviewed by a mental health professional who is employed by or under contract with the provider entity;~~

~~(2) functional assessments;~~

~~(3) individual treatment plans signed by the recipient and the mental health professional, or if the recipient refused to sign the plan, the date and reason stated by the recipient as to why the recipient would not sign the plan;~~

~~(4) recipient history;~~

~~(5) signed release forms;~~

~~(6) recipient health information and current medications;~~

~~(7) emergency contacts for the recipient;~~

~~(8) case records which document the date of service, the place of service delivery, signature of the person providing the service, nature, extent and units of service, and place of service delivery;~~

~~(9) contacts, direct or by telephone, with recipient's family or others, other providers, or other resources for service coordination;~~

~~(10) summary of recipient case reviews by staff; and~~

~~(11) written information by the recipient that the recipient requests be included in the file.~~

Sec. 71. Minnesota Statutes 2018, section 256B.0623, subdivision 12, is amended to read:

Subd. 12. **Additional requirements.** (a) Providers of adult rehabilitative mental health services must comply with the requirements relating to referrals for case management in section 245.467, subdivision 4.

(b) Adult rehabilitative mental health services are provided for most recipients in the recipient's home and community. Services may also be provided at the home of a relative or significant other, job site, psychosocial clubhouse, drop-in center, social setting, classroom, or other places in the community. Except for "transition to community services," the place of service does not include a regional treatment center, nursing home, residential treatment facility licensed under Minnesota Rules, parts 9520.0500 to 9520.0670 (Rule 36), or an acute care hospital.

(c) Adult rehabilitative mental health services may be provided in group settings if appropriate to each participating recipient's needs and treatment plan. A group is defined as two to ten clients, at least one of whom is a recipient, who is concurrently receiving a service which is identified in this section. The service and group must be specified in the recipient's treatment plan. No more than two qualified staff may bill Medicaid for services provided to the same group of recipients. If two adult rehabilitative mental health workers bill for recipients in the same group session, they must each bill for different recipients.

(d) Adult rehabilitative mental health services are appropriate if provided to enable a recipient to retain stability and functioning, when the recipient is at risk of significant functional decompensation or requiring more restrictive service settings without these services.

(e) Adult rehabilitative mental health services instruct, assist, and support the recipient in areas including: interpersonal communication skills, community resource utilization and integration skills, crisis planning, relapse prevention skills, health care directives, budgeting and shopping skills, healthy lifestyle skills and practices, cooking and nutrition skills, transportation skills, medication education and monitoring, mental illness symptom management skills, household management skills, employment-related skills, parenting skills, and transition to community living services.

Sec. 72. Minnesota Statutes 2018, section 256B.0624, subdivision 2, is amended to read:

Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings given them.

(a) "Mental health crisis" is an adult behavioral, emotional, or psychiatric situation which, but for the provision of crisis response services, would likely result in significantly reduced levels of functioning in primary activities of daily living, or in an emergency situation, or in the placement of the recipient in a more restrictive setting, including, but not limited to, inpatient hospitalization.

(b) "Mental health emergency" is an adult behavioral, emotional, or psychiatric situation which causes an immediate need for mental health services and is consistent with section 62Q.55.

A mental health crisis or emergency is determined for medical assistance service reimbursement by a physician, a mental health professional, or ~~crisis mental health practitioner~~ qualified member of a crisis team with input from the recipient whenever possible.

(c) "Mental health crisis assessment" means an immediate face-to-face assessment by a physician, a mental health professional, or ~~mental health practitioner under the clinical supervision of a mental health professional,~~ qualified member of a crisis team following a screening that suggests that the adult may be experiencing a mental health crisis or mental health emergency situation. It includes, when feasible, assessing whether the person might be willing to voluntarily accept treatment, determining whether the person has an advance directive, and obtaining information and history from involved family members or caretakers.

(d) "Mental health mobile crisis intervention services" means face-to-face, short-term intensive mental health services initiated during a mental health crisis or mental health emergency to help the recipient cope with immediate stressors, identify and utilize available resources and strengths, engage in voluntary treatment, and begin to return to the recipient's baseline level of functioning. The services, including screening and treatment plan recommendations, must be culturally and linguistically appropriate.

(1) This service is provided on site by a mobile crisis intervention team outside of an inpatient hospital setting. Mental health mobile crisis intervention services must be available 24 hours a day, seven days a week.

(2) The initial screening must consider other available services to determine which service intervention would best address the recipient's needs and circumstances.

(3) The mobile crisis intervention team must be available to meet promptly face-to-face with a person in mental health crisis or emergency in a community setting or hospital emergency room.

(4) The intervention must consist of a mental health crisis assessment and a crisis treatment plan.

(5) The team must be available to individuals who are experiencing a co-occurring substance use disorder, who do not need the level of care provided in a detoxification facility.

(6) The treatment plan must include recommendations for any needed crisis stabilization services for the recipient, including engagement in treatment planning and family psychoeducation.

(e) "Mental health crisis stabilization services" means individualized mental health services provided to a recipient following crisis intervention services which are designed to restore the recipient to the recipient's prior functional level. Mental health crisis stabilization services may be provided in the recipient's home, the home of a family member or friend of the recipient, another community setting, or a short-term supervised, licensed

residential program. Mental health crisis stabilization does not include partial hospitalization or day treatment. Mental health crisis stabilization services includes family psychoeducation.

(f) "Clinical trainee" means a person qualified according to section 245I.16, subdivision 6.

(g) "Mental health certified family peer specialist" means a person qualified according to section 245I.16, subdivision 12.

(h) "Mental health certified peer specialist" means a person qualified according to section 245I.16, subdivision 10.

(i) "Mental health practitioner" means a person qualified according to section 245I.16, subdivision 4.

(j) "Mental health professional" means a person qualified according to section 245I.16, subdivision 2.

(k) "Mental health rehabilitation worker" means a person qualified according to section 245I.16, subdivision 14.

Sec. 73. Minnesota Statutes 2018, section 256B.0624, subdivision 4, is amended to read:

Subd. 4. **Provider entity standards.** (a) A provider entity is an entity that meets the standards listed in paragraph (c) and:

(1) is a county board operated entity; ~~or~~

(2) is an Indian health service facility or facility owned and operated by a tribe or a tribal organization operating under United States Code, title 25, section 450f; or

(3) is a provider entity that is under contract with the county board in the county where the potential crisis or emergency is occurring. To provide services under this section, the provider entity must directly provide the services; or if services are subcontracted, the provider entity must maintain responsibility for services and billing.

(b) A provider entity that provides crisis stabilization services in a residential setting under subdivision 7 is not required to meet the requirements of paragraph (a), clauses (1) ~~and (2)~~ to (3), and paragraph (c), clauses (9), (20), and (21), but must meet all other requirements of this subdivision. Upon approval by the commissioner, a residential crisis services provider meeting relevant standards for supervision and assessment may allow a practitioner to perform a crisis assessment to establish eligibility for admission to the program. A provider performing an assessment under this paragraph shall not bill separately beyond the daily rate for the residential stabilization program.

(c) The adult mental health crisis response services provider entity must have the capacity to meet and carry out the requirements in chapter 245I and the following standards:

(1) has the capacity to recruit, hire, and manage and train ~~mental health professionals, practitioners, and rehabilitation workers~~ qualified staff;

(2) has adequate administrative ability to ensure availability of services;

(3) is able to ensure adequate preservice and in-service training;

(4) is able to ensure that staff providing these services are skilled in the delivery of mental health crisis response services to recipients;

(5) is able to ensure that staff are capable of implementing culturally specific treatment identified in the individual treatment plan that is meaningful and appropriate as determined by the recipient's culture, beliefs, values, and language;

(6) is able to ensure enough flexibility to respond to the changing intervention and care needs of a recipient as identified by the recipient during the service partnership between the recipient and providers;

(7) is able to ensure that ~~mental health professionals and mental health practitioners~~ staff have the communication tools and procedures to communicate and consult promptly about crisis assessment and interventions as services occur;

(8) is able to coordinate these services with county emergency services, community hospitals, ambulance, transportation services, social services, law enforcement, and mental health crisis services through regularly scheduled interagency meetings;

(9) is able to ensure that mental health crisis assessment and mobile crisis intervention services are available 24 hours a day, seven days a week;

(10) is able to ensure that services are coordinated with other mental health service providers, county mental health authorities, or federally recognized American Indian authorities and others as necessary, with the consent of the adult. Services must also be coordinated with the recipient's case manager if the adult is receiving case management services;

(11) is able to coordinate services with detoxification or withdrawal management services to ensure a recipient receives care that is responsive to the recipient's chemical and mental health needs;

(12) is able to ensure that crisis intervention services are provided in a manner consistent with sections 245.461 to 245.486;

~~(12)~~ (13) is able to submit information as required by the state;

~~(13)~~ (14) maintains staff training and personnel files, including documentation of staff completion of required training modules;

~~(14)~~ (15) is able to establish and maintain a quality assurance and evaluation plan to evaluate the outcomes of services and recipient satisfaction, including notifying recipients of the process by which the provider, county, or tribe accepts and responds to concerns;

~~(15)~~ (16) is able to keep records as required by applicable laws;

~~(16)~~ (17) is able to comply with all applicable laws and statutes;

~~(17)~~ (18) is an enrolled medical assistance provider; ~~and~~

~~(18)~~ (19) develops and maintains written policies and procedures regarding service provision and administration of the provider entity, including safety of staff and recipients in high-risk situations~~.~~;

(20) is able to respond to a call for crisis services in a designated service area or according to a written agreement with the local mental health authority for an adjacent area; and

(21) documents protocol used when delivering services by telemedicine, according to sections 62A.67 to 62A.672, including responsibilities of the originating site, means to promote recipient safety, timeliness for connection and response, and steps to take in the event of a lost connection.

Sec. 74. Minnesota Statutes 2018, section 256B.0624, subdivision 5, is amended to read:

Subd. 5. **Mobile crisis intervention staff qualifications.** ~~For provision of adult mental health mobile crisis intervention services, a mobile crisis intervention team is comprised of at least two mental health professionals as defined in section 245.462, subdivision 18, clauses (1) to (6), or a combination of at least one mental health professional and one mental health practitioner as defined in section 245.462, subdivision 17, with the required mental health crisis training and under the clinical supervision of a mental health professional on the team.~~

(a) Mobile crisis intervention team staff must be qualified to provide services as mental health professionals, mental health practitioners, clinical trainees, mental health certified family peer specialists, or mental health certified peer specialists.

(b) A mobile crisis intervention team is comprised of at least two members, one of whom must be qualified as a mental health professional. A second member must be qualified as a mental health professional, clinical trainee, or mental health practitioner. A provider entity must consider the needs of the area served when adding staff.

(c) Mental health crisis assessment and intervention services must be led by a mental health professional, or under the supervision of a mental health professional according to subdivision 9, by a clinical trainee or mental health practitioner.

(d) The team must have ~~at least two people with~~ at least one member providing on-site crisis intervention services when needed. Team members must be experienced in mental health assessment, crisis intervention techniques, treatment engagement strategies, working with families, and clinical decision-making under emergency conditions and have knowledge of local services and resources. The team must recommend and coordinate the team's services with appropriate local resources such as the county social services agency, mental health services, and local law enforcement when necessary.

Sec. 75. Minnesota Statutes 2018, section 256B.0624, subdivision 6, is amended to read:

Subd. 6. **Crisis assessment and mobile intervention treatment planning.** (a) Prior to initiating mobile crisis intervention services, a screening of the potential crisis situation must be conducted. The screening may use the resources of crisis ~~assistance~~ planning and emergency services as defined in sections 245.462, subdivision 6, and 245.469, subdivisions 1 and 2. The screening must gather information, determine whether a crisis situation exists, identify parties involved, and determine an appropriate response.

(b) In conducting the screening, a provider shall:

(1) employ evidence-based practices as identified by the commissioner in collaboration with the commissioner of health to reduce the risk of the recipient's suicide and self-injurious behavior;

(2) work with the recipient to establish a plan and time frame for responding to the crisis, including immediate needs for support by telephone or text message until a face-to-face response arrives;

(3) document significant factors related to the determination of a crisis, including prior calls to the crisis team, recent presentation at an emergency department, known calls to 911 or law enforcement, or the presence of third parties with knowledge of a potential recipient's history or current needs;

(4) screen for the needs of a third-party caller, including a recipient who primarily identifies as a family member or a caregiver but also presents signs of a crisis; and

(5) provide psychoeducation, including education on the available means for reducing self-harm, to relevant third parties, including family members or other persons living in the home.

(c) A provider entity shall consider the following to indicate a positive screening unless the provider entity documents specific evidence to show why crisis response was clinically inappropriate:

(1) the recipient presented in an emergency department or urgent care setting, and the health care team at that location requested crisis services; or

(2) a peace officer requested crisis services for a recipient who may be subject to transportation under section 253B.05 for a mental health crisis.

~~(b)~~ (d) If a crisis exists, a crisis assessment must be completed. A crisis assessment evaluates any immediate needs for which emergency services are needed and, as time permits, the recipient's current life situation, sources of stress, mental health problems and symptoms, strengths, cultural considerations, support network, vulnerabilities, current functioning, and the recipient's preferences as communicated directly by the recipient, or as communicated in a health care directive as described in chapters 145C and 253B, the treatment plan described under paragraph (d), a crisis prevention plan, or a wellness recovery action plan.

~~(c)~~ (e) If the crisis assessment determines mobile crisis intervention services are needed, the intervention services must be provided promptly. As opportunity presents during the intervention, at least two members of the mobile crisis intervention team must confer directly or by telephone about the assessment, treatment plan, and actions taken and needed. At least one of the team members must be on site providing crisis intervention services. If providing on-site crisis intervention services, a mental health practitioner must seek ~~clinical~~ treatment supervision as required in subdivision 9.

(f) Direct contact with the recipient is not required before initiating a crisis assessment or intervention service. A crisis team may gather relevant information from a third party at the scene to establish the need for services and potential safety factors. A crisis assessment is provided face-to-face by a mobile crisis intervention team outside of an inpatient hospital setting. A service must be provided promptly and respond to the recipient's location whenever possible, including community or clinical settings. As clinically appropriate, a mobile crisis intervention team must coordinate a response with other health care providers if a recipient requires detoxification, withdrawal management, or medical stabilization services in addition to crisis services.

~~(d)~~ (g) The mobile crisis intervention team must develop an initial, brief crisis treatment plan as soon as appropriate but no later than 24 hours after the initial face-to-face intervention. The plan must address the needs and problems noted in the crisis assessment and include

measurable short-term goals, cultural considerations, and frequency and type of services to be provided to achieve the goals and reduce or eliminate the crisis. The treatment plan must be updated as needed to reflect current goals and services.

~~(e)~~ (h) The team must document which short-term goals have been met and when no further crisis intervention services are required. If after an assessment a crisis provider entity refers a recipient to an intensive setting, including an emergency department, in-patient hospitalization, or crisis residential treatment, one of the crisis team members who performed or conferred on the assessment must immediately contact the provider entity and consult with the triage nurse or other staff responsible for intake. The crisis team member must convey key findings or concerns that led to the referral. The consultation shall occur with the recipient's consent, the recipient's legal guardian's consent, or as allowed by section 144.293, subdivision 5. Any available written documentation, including a crisis treatment plan, must be sent no later than the next business day.

~~(f)~~ (i) If the recipient's crisis is stabilized, but the recipient needs a referral to other services, the team must provide referrals to these services. If the recipient has a case manager, planning for other services must be coordinated with the case manager. If the recipient is unable to follow up on the referral, the team must link the recipient to the service and follow up to ensure the recipient is receiving the service.

~~(g)~~ (j) If the recipient's crisis is stabilized and the recipient does not have an advance directive, the case manager or crisis team shall offer to work with the recipient to develop one.

Sec. 76. Minnesota Statutes 2018, section 256B.0624, subdivision 8, is amended to read:

Subd. 8. **Adult crisis stabilization staff qualifications.** (a) Adult mental health crisis stabilization services must be provided by qualified individual staff of a qualified provider entity. Individual provider staff must ~~have the following qualifications~~ be:

(1) ~~be~~ a mental health professional ~~as defined in section 245.462, subdivision 18, clauses (1) to (6)~~;

(2) ~~be~~ a mental health practitioner ~~as defined in section 245.462, subdivision 17. The mental health practitioner must work under the clinical supervision of a mental health professional~~;

(3) ~~be~~ a mental health certified peer specialist ~~under section 256B.0615. The certified peer specialist must work under the clinical supervision of a mental health professional~~; or

(4) ~~be~~ a mental health rehabilitation worker ~~who meets the criteria in section 256B.0623, subdivision 5, paragraph (a), clause (4); works under the direction of a mental health practitioner as defined in section 245.462, subdivision 17, or under direction of a mental health professional; and works under the clinical supervision of a mental health professional~~.

(b) Mental health practitioners, clinical trainees, and mental health rehabilitation workers must have completed at least 30 hours of training in crisis intervention and stabilization during the past two years.

Sec. 77. Minnesota Statutes 2018, section 256B.0624, subdivision 9, is amended to read:

Subd. 9. **Supervision.** Mental health practitioners or clinical trainees may provide crisis assessment and mobile crisis intervention services if the following ~~clinical~~ treatment supervision requirements are met:

(1) the mental health provider entity must accept full responsibility for the services provided;

(2) the mental health professional of the provider entity, who is an employee or under contract with the provider entity, must be immediately available by phone or in person for clinical supervision;

(3) the mental health professional is consulted, in person or by phone, during the first three hours when a mental health practitioner or clinical trainee provides on-site service;

(4) the mental health professional must:

(i) review and approve of the tentative crisis assessment and crisis treatment plan;

(ii) document the consultation; and

(iii) sign the crisis assessment and treatment plan within the next business day; and

~~(5) if the mobile crisis intervention services continue into a second calendar day, a mental health professional must contact the recipient face-to-face on the second day to provide services and update the crisis treatment plan; and~~

~~(6)~~ (5) the on-site observation must be documented in the recipient's record and signed by the mental health professional.

Sec. 78. Minnesota Statutes 2018, section 256B.0624, subdivision 10, is amended to read:

Subd. 10. **Recipient file.** Providers of mobile crisis intervention or crisis stabilization services must maintain a file for each recipient containing the following information:

(1) individual crisis treatment plans signed by the recipient, mental health professional, and mental health practitioner who developed the crisis treatment plan, or if the recipient refused to sign the plan, the date and reason stated by the recipient as to why the recipient would not sign the plan;

(2) signed release forms;

(3) recipient health information and current medications;

(4) emergency contacts for the recipient;

(5) case records which document the date of service, place of service delivery, signature of the person providing the service, and the nature, extent, and units of service. Direct or telephone contact with the recipient's family or others should be documented;

(6) required ~~clinical~~ treatment supervision by mental health professionals;

(7) summary of the recipient's case reviews by staff;

(8) any written information by the recipient that the recipient wants in the file; and

(9) an advance directive, if there is one available.

Documentation in the file must comply with all requirements of the commissioner.

Sec. 79. Minnesota Statutes 2018, section 256B.0624, subdivision 11, is amended to read:

Subd. 11. **Treatment plan.** The individual crisis stabilization treatment plan must include, at a minimum:

(1) a list of problems identified in the assessment;

(2) a list of the recipient's strengths and resources;

(3) concrete, measurable short-term goals and tasks to be achieved, including time frames for achievement;

(4) specific objectives directed toward the achievement of each one of the goals;

(5) documentation of the participants involved in the service planning. The recipient, if possible, must be a participant. The recipient or the recipient's legal guardian must sign the service plan or documentation must be provided why this was not possible. A copy of the plan must be given to the recipient and the recipient's legal guardian. The plan should include services arranged, including specific providers where applicable;

(6) planned frequency and type of services initiated;

(7) a crisis response action plan if a crisis should occur;

(8) clear progress notes on outcome of goals;

(9) a written plan must be completed within 24 hours of beginning services with the recipient; and

(10) a treatment plan must be developed by a mental health professional, clinical trainee, or mental health practitioner ~~under the clinical supervision of a mental health professional~~. The mental health professional must approve and sign all treatment plans.

Sec. 80. Minnesota Statutes 2018, section 256B.0625, subdivision 3b, is amended to read:

Subd. 3b. **Telemedicine services.** (a) Medical assistance covers medically necessary services and consultations delivered by a licensed health care provider via telemedicine in the same manner as if the service or consultation was delivered in person. Coverage is limited to three telemedicine services per enrollee per calendar week. Telemedicine services shall be paid at the full allowable rate.

(b) The commissioner shall establish criteria that a health care provider must attest to in order to demonstrate the safety or efficacy of delivering a particular service via telemedicine. The attestation may include that the health care provider:

(1) has identified the categories or types of services the health care provider will provide via telemedicine;

(2) has written policies and procedures specific to telemedicine services that are regularly reviewed and updated;

(3) has policies and procedures that adequately address patient safety before, during, and after the telemedicine service is rendered;

(4) has established protocols addressing how and when to discontinue telemedicine services; and

(5) has an established quality assurance process related to telemedicine services.

(c) As a condition of payment, a licensed health care provider must document each occurrence of a health service provided by telemedicine to a medical assistance enrollee. Health care service records for services provided by telemedicine must meet the requirements set forth in Minnesota Rules, part 9505.2175, subparts 1 and 2, and must document:

(1) the type of service provided by telemedicine;

(2) the time the service began and the time the service ended, including an a.m. and p.m. designation;

(3) the licensed health care provider's basis for determining that telemedicine is an appropriate and effective means for delivering the service to the enrollee;

(4) the mode of transmission of the telemedicine service and records evidencing that a particular mode of transmission was utilized;

(5) the location of the originating site and the distant site;

(6) if the claim for payment is based on a physician's telemedicine consultation with another physician, the written opinion from the consulting physician providing the telemedicine consultation; and

(7) compliance with the criteria attested to by the health care provider in accordance with paragraph (b).

(d) For purposes of this subdivision, unless otherwise covered under this chapter, "telemedicine" is defined as the delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site. A communication between licensed health care providers, or a licensed health care provider and a patient that consists solely of a telephone conversation, e-mail, or facsimile transmission does not constitute telemedicine consultations or services. Telemedicine may be provided by means of real-time two-way, interactive audio and visual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health care delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care.

(e) For purposes of this section, "licensed health care provider" means a licensed health care provider under section 62A.671, subdivision 6, a clinical trainee, and a mental health practitioner defined under section 245.462, subdivision 17~~, or 245.4871, subdivision 26~~, working under the general supervision of a mental health professional; "health care provider" is defined under section 62A.671, subdivision 3; and "originating site" is defined under section 62A.671, subdivision 7.

Sec. 81. Minnesota Statutes 2018, section 256B.0625, subdivision 5, is amended to read:

Subd. 5. **Community mental health center services.** Medical assistance covers community mental health center services provided by a community mental health center that meets the requirements in paragraphs (a) to (j).

(a) The provider is licensed under Minnesota Rules, parts 9520.0750 to 9520.0870, and in compliance with requirements under chapter 245I and section 256B.0671.

(b) The provider provides mental health services under the ~~clinical~~ treatment supervision of a mental health professional who is licensed for independent practice at the doctoral level or by a board-certified psychiatrist or a psychiatrist who is eligible for board certification. ~~Clinical supervision has the meaning given in Minnesota Rules, part 9505.0370, subpart 6.~~ Treatment supervision means the treatment supervision described under section 245I.18.

(c) The provider must be a private nonprofit corporation or a governmental agency and have a community board of directors as specified by section 245.66.

(d) The provider must have a sliding fee scale that meets the requirements in section 245.481, and agree to serve within the limits of its capacity all individuals residing in its service delivery area.

(e) At a minimum, the provider must provide the following outpatient mental health services: diagnostic assessment; explanation of findings; and family, group, and individual psychotherapy, including crisis intervention psychotherapy services~~, multiple family group psychotherapy~~, psychological testing, and medication management. In addition, the provider must provide or be capable of providing upon request of the local mental health authority day treatment services, multiple family group psychotherapy, and professional home-based mental health services. The provider must have the capacity to provide such services to specialized populations such as the elderly, families with children, persons who are seriously and persistently mentally ill, and children who are seriously emotionally disturbed.

(f) The provider must be capable of providing the services specified in paragraph (e) to individuals who are dually diagnosed with ~~both~~ a mental illness or emotional disturbance~~,~~ and ~~chemical dependency~~ substance use disorder, and to individuals who are dually diagnosed with a mental illness or emotional disturbance and developmental disability.

(g) The provider must provide 24-hour emergency care services or demonstrate the capacity to assist recipients in need of such services to access such services on a 24-hour basis.

(h) The provider must have a contract with the local mental health authority to provide one or more of the services specified in paragraph (e).

(i) The provider must agree, upon request of the local mental health authority, to enter into a contract with the county to provide mental health services not reimbursable under the medical assistance program.

(j) The provider may not be enrolled with the medical assistance program as both a hospital and a community mental health center. The community mental health center's

administrative, organizational, and financial structure must be separate and distinct from that of the hospital.

Sec. 82. Minnesota Statutes 2018, section 256B.0625, subdivision 5l, is amended to read:

Subd. 5l. **Intensive mental health outpatient treatment.** (a) Medical assistance covers intensive mental health outpatient treatment for dialectical behavioral therapy for adults. The commissioner shall establish:

(1) certification procedures to ensure that providers of these services are qualified and meet the standards in chapter 245I; and

(2) treatment protocols including required service components and criteria for admission, continued treatment, and discharge.

(b) "Dialectical behavior therapy" means an evidence-based treatment approach provided in an intensive outpatient treatment program using a combination of individualized rehabilitative and psychotherapeutic interventions. A dialectical behavior therapy program involves the following service components: individual dialectical behavior therapy, group skills training, telephone coaching, and team consultation meetings.

(c) To be eligible for dialectical behavior therapy a client must:

(1) be 18 years of age or older;

(2) have mental health needs that cannot be met with other available community-based services or that must be provided concurrently with other community-based services;

(3) meet one of the following criteria:

(i) have a diagnosis of borderline personality disorder; or

(ii) have multiple mental health diagnoses, exhibit behaviors characterized by impulsivity or intentional self-harm, and be at significant risk of death, morbidity, disability, or severe dysfunction across multiple life areas;

(4) understand and be cognitively capable of participating in dialectical behavior therapy as an intensive therapy program and be able and willing to follow program policies and rules ensuring safety of self and others; and

(5) be at significant risk of one or more of the following if dialectical behavior therapy is not provided:

(i) having a mental health crisis;

(ii) requiring a more restrictive setting including hospitalization;

(iii) decompensation; or

(iv) engaging in intentional self-harm behavior.

(d) Individual dialectical behavior therapy combines individualized rehabilitative and psychotherapeutic interventions to treat suicidal and other dysfunctional behaviors and reinforce the use of adaptive skillful behaviors. Individual dialectical behavior therapy must be provided by a mental health professional or a clinical trainee. The mental health professional or clinical trainee must:

(1) identify, prioritize, and sequence behavioral targets;

(2) treat behavioral targets;

(3) generalize dialectical behavior therapy skills to the client's natural environment through telephone coaching outside of the treatment session;

(4) measure the client's progress toward dialectical behavior therapy targets;

(5) help the client manage mental health crises and life-threatening behaviors; and

(6) help the client learn and apply effective behaviors when working with other treatment providers.

(e) Group skills training combines individualized psychotherapeutic and psychiatric rehabilitative interventions conducted in a group setting to reduce the client's suicidal and other dysfunctional coping behaviors and restore function. Group skills training must teach the client adaptive skills in the following areas:

(1) mindfulness;

(2) interpersonal effectiveness;

(3) emotional regulation; and

(4) distress tolerance.

(f) Group skills training must be provided by two mental health professionals, or by a mental health professional co-facilitating with a clinical trainee or a mental health practitioner as specified in section 245I.16, subdivision 4. Individual skills training must be provided by a mental health professional, a clinical trainee, or a mental health practitioner as specified in section 245I.16, subdivision 4.

(g) A program must be certified by the commissioner as a dialectical behavior therapy provider. To qualify for certification, a provider must:

(1) hold current accreditation as a dialectical behavior therapy program from a nationally recognized certification body approved by the commissioner;

(2) submit to the commissioner's inspection;

(3) provide evidence that the dialectical behavior therapy program's policies, procedures, and practices continuously meet the requirements of this subdivision;

(4) be enrolled as a MHCP provider;

(5) collect and report client outcomes as specified by the commissioner; and

(6) have a manual that outlines the dialectical behavior therapy program's policies, procedures, and practices that meet the requirements of this subdivision.

Sec. 83. Minnesota Statutes 2018, section 256B.0625, subdivision 19c, is amended to read:

Subd. 19c. **Personal care.** Medical assistance covers personal care assistance services provided by an individual who is qualified to provide the services according to subdivision 19a and sections 256B.0651 to 256B.0654, provided in accordance with a plan, and supervised by a qualified professional.

"Qualified professional" means a mental health professional as defined in section 245.462, subdivision 18, ~~clauses (1) to (6),~~ or 245.4871, subdivision 27~~, clauses (1) to (6)~~; a registered nurse as defined in sections 148.171 to 148.285, a licensed social worker as defined in sections 148E.010 and 148E.055, or a qualified designated coordinator under section 245D.081, subdivision 2. The qualified professional shall perform the duties required in section 256B.0659.

Sec. 84. Minnesota Statutes 2018, section 256B.0625, subdivision 23, is amended to read:

Subd. 23. **Adult day treatment services.** (a) Medical assistance covers adult day treatment services as specified in sections 245.462, subdivision 8, and 245.4871, subdivision 10, that are provided under contract with the county board. The commissioner may set authorization thresholds for day treatment for adults according to subdivision 25. Medical assistance covers day treatment services for children as specified under section 256B.0943. Adult day treatment payment is limited to the conditions in paragraphs (b) to (e).

(b) Adult day treatment is an intensive psychotherapeutic treatment to reduce or relieve the effects of mental illness to enable the client to benefit from a lower level of care and to live and function more independently in the community. Adult day treatment services must

stabilize the client's mental health status and develop and improve the client's independent living and socialization skills. Adult day treatment must consist of at least one hour of group psychotherapy and must include group time focused on rehabilitative interventions or other therapeutic services that are provided by a multidisciplinary staff person. Adult day treatment services are not a part of inpatient or residential treatment services.

(c) To be eligible for medical assistance payment, an adult day treatment service must:

(1) be reviewed by and approved by the commissioner;

(2) be provided to a group of clients by a multidisciplinary staff person under the treatment supervision of a mental health professional as described under section 245I.18;

(3) be available to the client at least two days a week for at least three consecutive hours per day. The adult day treatment may be longer than three hours per day, but medical assistance must not reimburse a provider for more than 15 hours per week;

(4) include group psychotherapy by a mental health professional or clinical trainee and daily rehabilitative interventions by a mental health professional qualified according to section 245I.16, subdivision 2, clinical trainee qualified according to section 245I.16, subdivision 6, or mental health practitioner qualified according to section 245I.16, subdivision 4;

(5) be included in the client's individual treatment plan as described under section 256B.0671, subdivisions 5 and 6, as appropriate. The individual treatment plan must include attainable, measurable goals related to services and must be completed before the first adult day treatment session. The vendor must review the client's progress and update the treatment plan at least every 30 days until the client is discharged and include an available discharge plan for the client in the treatment plan; and

(6) document the daily interventions provided and the client's response according to section 245I.33.

(d) To be eligible for adult day treatment, a client must:

(1) be 18 years of age or older;

(2) not be residing in a nursing facility, hospital, institute of mental disease, or regional treatment center unless the client has an active discharge plan that indicates a move to an independent living arrangement within 180 days;

(3) have a diagnosis of mental illness as determined by a diagnostic assessment;

(4) have the capacity to engage in the rehabilitative nature, the structured setting, and the therapeutic parts of psychotherapy and skills activities of an adult day treatment program and demonstrate measurable improvements in the client's functioning related to the client's mental illness that would result from participating in the adult day treatment program;

(5) have at least three areas of functional impairment as determined by a functional assessment with the domains prescribed by section 245.462, subdivision 11a;

(6) have a level of care determination that supports the need for the level of intensity and duration of an adult day treatment program; and

(7) be determined to need adult day treatment services by a mental health professional who must deem the adult day treatment services medically necessary.

(e) The following services are not covered by medical assistance as an adult day treatment service:

(1) a service that is primarily recreation-oriented or that is provided in a setting that is not medically supervised. This includes sports activities, exercise groups, craft hours, leisure time, social hours, meal or snack time, trips to community activities, and tours;

(2) a social or educational service that does not have or cannot reasonably be expected to have a therapeutic outcome related to the client's mental illness;

(3) consultation with other providers or service agency staff persons about the care or progress of a client;

(4) prevention or education programs provided to the community;

(5) day treatment for clients with primary diagnoses of alcohol or other drug abuse;

(6) day treatment provided in the client's home;

(7) psychotherapy for more than two hours per day; and

(8) participation in meal preparation and eating that is not part of a clinical treatment plan to address the client's eating disorder.

Sec. 85. Minnesota Statutes 2018, section 256B.0625, subdivision 42, is amended to read:

Subd. 42. **Mental health professional.** Notwithstanding Minnesota Rules, part 9505.0175, subpart 28, the definition of a mental health professional shall include a person who is qualified as specified in section 245.462, subdivision 18~~, clauses (1) to (6)~~; or 245.4871, subdivision 27, ~~clauses (1) to (6),~~ for the purpose of this section and Minnesota Rules, parts 9505.0170 to 9505.0475.

Sec. 86. Minnesota Statutes 2018, section 256B.0625, subdivision 48, is amended to read:

Subd. 48. **Psychiatric consultation to primary care practitioners.** Medical assistance covers consultation provided by a ~~psychiatrist, a psychologist, an advanced practice registered nurse certified in psychiatric mental health, a licensed independent clinical social worker, as defined in section 245.462, subdivision 18, clause (2), or a licensed marriage and family therapist, as defined in section 245.462, subdivision 18, clause (5),~~ mental health professional except one licensed under section 148B.5301 via telephone, e-mail, facsimile, or other means of communication to primary care practitioners, including pediatricians. The need for consultation and the receipt of the consultation must be documented in the patient record maintained by the primary care practitioner. If the patient consents, and subject to federal limitations and data privacy provisions, the consultation may be provided without the patient present.

Sec. 87. Minnesota Statutes 2018, section 256B.0625, subdivision 49, is amended to read:

Subd. 49. **Community health worker.** (a) Medical assistance covers the care coordination and patient education services provided by a community health worker if the community health worker has~~: (1)~~ received a certificate from the Minnesota State Colleges and Universities System approved community health worker curriculum~~; or~~.

~~(2) at least five years of supervised experience with an enrolled physician, registered nurse, advanced practice registered nurse, mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6), and section 245.4871, subdivision 27, clauses (1) to (5), or dentist, or at least five years of supervised experience by a certified public health nurse operating under the direct authority of an enrolled unit of government.~~

~~Community health workers eligible for payment under clause (2) must complete the certification program by January 1, 2010, to continue to be eligible for payment.~~

(b) Community health workers must work under the supervision of a medical assistance enrolled physician, registered nurse, advanced practice registered nurse, mental health professional as defined in section 245.462, subdivision 18, ~~clauses (1) to (6),~~ and section 245.4871, subdivision 27, ~~clauses (1) to (5),~~ or dentist, or work under the supervision of a certified public health nurse operating under the direct authority of an enrolled unit of government.

(c) Care coordination and patient education services covered under this subdivision include, but are not limited to, services relating to oral health and dental care.

Sec. 88. Minnesota Statutes 2018, section 256B.0625, subdivision 56a, is amended to read:

Subd. 56a. **Post-arrest community-based service coordination.** (a) Medical assistance covers post-arrest community-based service coordination for an individual who:

(1) has been identified as having a mental illness or substance use disorder using a screening tool approved by the commissioner;

(2) does not require the security of a public detention facility and is not considered an inmate of a public institution as defined in Code of Federal Regulations, title 42, section 435.1010;

(3) meets the eligibility requirements in section 256B.056; and

(4) has agreed to participate in post-arrest community-based service coordination through a diversion contract in lieu of incarceration.

(b) Post-arrest community-based service coordination means navigating services to address a client's mental health, chemical health, social, economic, and housing needs, or any other activity targeted at reducing the incidence of jail utilization and connecting individuals with existing covered services available to them, including, but not limited to, targeted case management, waiver case management, or care coordination.

(c) Post-arrest community-based service coordination must be provided by an individual who is an employee of a county or is under contract with a county to provide post-arrest community-based coordination and is qualified under one of the following criteria:

(1) a licensed mental health professional as defined in section 245.462, subdivision 18~~, clauses (1) to (6)~~;

(2) a mental health practitioner as defined in section 245.462, subdivision 17, working under the ~~clinical~~ treatment supervision of a mental health professional; ~~or~~

(3) a certified peer specialist under section 256B.0615, working under the ~~clinical~~ treatment supervision of a mental health professional~~.~~; or

(4) a clinical trainee.

(d) Reimbursement is allowed for up to 60 days following the initial determination of eligibility.

(e) Providers of post-arrest community-based service coordination shall annually report to the commissioner on the number of individuals served, and number of the community-based services that were accessed by recipients. The commissioner shall ensure

that services and payments provided under post-arrest community-based service coordination do not duplicate services or payments provided under section 256B.0625, subdivision 20, 256B.0753, 256B.0755, or 256B.0757.

(f) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of cost for post-arrest community-based service coordination services shall be provided by the county providing the services, from sources other than federal funds or funds used to match other federal funds.

Sec. 89. Minnesota Statutes 2018, section 256B.0625, subdivision 61, is amended to read:

Subd. 61. **Family psychoeducation services.** ~~Effective July 1, 2013, or upon federal approval, whichever is later,~~ Medical assistance covers family psychoeducation services provided to a child up to age 21 with a diagnosed mental health condition when identified in the child's individual treatment plan and provided by a licensed mental health professional~~, as defined in Minnesota Rules, part 9505.0371, subpart 5, item A,~~ or a clinical trainee~~, as defined in Minnesota Rules, part 9505.0371, subpart 5, item C,~~ who has determined it medically necessary to involve family members in the child's care. For the purposes of this subdivision, "family psychoeducation services" means information or demonstration provided to an individual or family as part of an individual, family, multifamily group, or peer group session to explain, educate, and support the child and family in understanding a child's symptoms of mental illness, the impact on the child's development, and needed components of treatment and skill development so that the individual, family, or group can help the child to prevent relapse, prevent the acquisition of comorbid disorders, and achieve optimal mental health and long-term resilience.

Sec. 90. Minnesota Statutes 2018, section 256B.0625, subdivision 62, is amended to read:

Subd. 62. **Mental health clinical care consultation.** ~~Effective July 1, 2013, or upon federal approval, whichever is later,~~ Medical assistance covers clinical care consultation for a person up to age 21 who is diagnosed with a complex mental health condition or a mental health condition that co-occurs with other complex and chronic conditions, when described in the person's individual treatment plan and provided by a licensed mental health professional~~, as defined in Minnesota Rules, part 9505.0371, subpart 5, item A,~~ or a clinical trainee~~, as defined in Minnesota Rules, part 9505.0371, subpart 5, item C~~. For the purposes of this subdivision, "clinical care consultation" means communication from a treating mental health professional to other providers or educators not under the clinical supervision of the treating mental health professional who are working with the same client to inform, inquire,

and instruct regarding the client's symptoms; strategies for effective engagement, care, and intervention needs; and treatment expectations across service settings; and to direct and coordinate clinical service components provided to the client and family.

Sec. 91. Minnesota Statutes 2018, section 256B.0625, subdivision 65, is amended to read:

Subd. 65. **Outpatient mental health services.** For the purposes of this section, "clinical trainee" has the meaning given in section 245I.16, subdivision 6. Medical assistance covers diagnostic assessment, explanation of findings, and psychotherapy according to ~~Minnesota Rules, part 9505.0372,~~ subdivision 69 and section 256B.0671 when the mental health services are performed by ~~a mental health practitioner working as~~ a clinical trainee ~~according to section 245.462, subdivision 17, paragraph (g)~~.

Sec. 92. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision to read:

Subd. 66. **Neuropsychological assessment.** (a) "Neuropsychological assessment" means a specialized clinical assessment of the client's underlying cognitive abilities related to thinking, reasoning, and judgment that is conducted by a qualified neuropsychologist. A neuropsychological assessment must include a face-to-face interview with the client, interpretation of the test results, and preparation and completion of a report.

(b) A client is eligible for a neuropsychological assessment if at least one of the following criteria is met:

(1) there is a known or strongly suspected brain disorder based on medical history or neurological evaluation, including a history of significant head trauma, brain tumor, stroke, seizure disorder, multiple sclerosis, neurodegenerative disorder, significant exposure to neurotoxins, central nervous system infection, metabolic or toxic encephalopathy, fetal alcohol syndrome, or congenital malformation of the brain; or

(2) there are cognitive or behavioral symptoms that suggest that the client has an organic condition that cannot be readily attributed to functional psychopathology or suspected neuropsychological impairment in addition to functional psychopathology. This includes:

(i) poor memory or impaired problem solving;

(ii) change in mental status evidenced by lethargy, confusion, or disorientation;

(iii) deterioration in level of functioning;

(iv) marked behavioral or personality change;

(v) in children or adolescents, significant delays in academic skill acquisition or poor attention relative to peers;

(vi) in children or adolescents, significant plateau in expected development of cognitive, social, emotional, or physical function relative to peers; and

(vii) in children or adolescents, significant inability to develop expected knowledge, skills, or abilities as required to adapt to new or changing cognitive, social, emotional, or physical demands.

(c) The neuropsychological assessment must be conducted by a neuropsychologist competent in the area of neuropsychological assessment who:

(1) was awarded a diploma by the American Board of Clinical Neuropsychology, the American Board of Professional Neuropsychology, or the American Board of Pediatric Neuropsychology;

(2) earned a doctoral degree in psychology from an accredited university training program and:

(i) completed an internship or its equivalent in a clinically relevant area of professional psychology;

(ii) completed the equivalent of two full-time years of experience and specialized training, at least one of which is at the postdoctoral level, supervised by a clinical neuropsychologist in the study and practice of clinical neuropsychology and related neurosciences; and

(iii) holds a current license to practice psychology independently according to sections 144.88 to 144.98;

(3) is licensed or credentialed by another state's board of psychology examiners in the specialty of neuropsychology using requirements equivalent to requirements specified by one of the boards named in clause (1); or

(4) was approved by the commissioner as an eligible provider of neuropsychological assessment prior to December 31, 2010.

Sec. 93. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision to read:

Subd. 67. **Neuropsychological testing.** (a) "Neuropsychological testing" means administering standardized tests and measures designed to evaluate the client's ability to attend to, process, interpret, comprehend, communicate, learn, and recall information and use problem solving and judgment.

(b) Medical assistance covers neuropsychological testing when the client:

(1) has a significant mental status change that is not a result of a metabolic disorder and that has failed to respond to treatment;

(2) is a child or adolescent with a significant plateau in expected development of cognitive, social, emotional, or physical function relative to peers;

(3) is a child or adolescent with a significant inability to develop expected knowledge, skills, or abilities as required to adapt to new or changing cognitive, social, physical, or emotional demands; or

(4) has a significant behavioral change, memory loss, or suspected neuropsychological impairment in addition to functional psychopathology, or other organic brain injury or one of the following:

(i) traumatic brain injury;

(ii) stroke;

(iii) brain tumor;

(iv) substance use disorder;

(v) cerebral anoxic or hypoxic episode;

(vi) central nervous system infection or other infectious disease;

(vii) neoplasms or vascular injury of the central nervous system;

(viii) neurodegenerative disorders;

(ix) demyelinating disease;

(x) extrapyramidal disease;

(xi) exposure to systemic or intrathecal agents or cranial radiation known to be associated with cerebral dysfunction;

(xii) systemic medical conditions known to be associated with cerebral dysfunction, including renal disease, hepatic encephalopathy, cardiac anomaly, sickle cell disease, and related hematologic anomalies, and autoimmune disorders, including lupus, erythematosis, or celiac disease;

(xiii) congenital genetic or metabolic disorders known to be associated with cerebral dysfunction, including phenylketonuria, craniofacial syndromes, or congenital hydrocephalus;

(xiv) severe or prolonged nutrition or malabsorption syndromes; or

(xv) a condition presenting in a manner difficult for a clinician to distinguish between the neurocognitive effects of a neurogenic syndrome, including dementia or encephalopathy; and a major depressive disorder when adequate treatment for major depressive disorder has not resulted in improvement in neurocognitive function; or another disorder, including autism, selective mutism, anxiety disorder, or reactive attachment disorder.

(c) Neuropsychological testing must be administered or clinically supervised by a neuropsychologist qualified as defined in subdivision 66, paragraph (c).

(d) Neuropsychological testing is not covered when performed: (1) primarily for educational purposes; (2) primarily for vocational counseling or training; (3) for personnel or employment testing; (4) as a routine battery of psychological tests given at inpatient admission or during a continued stay; or (5) for legal or forensic purposes.

Sec. 94. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision to read:

Subd. 68. **Psychological testing.** (a) "Psychological testing" means the use of tests or other psychometric instruments to determine the status of the client's mental, intellectual, and emotional functioning.

(b) The psychological testing must:

(1) be administered or clinically supervised by a licensed psychologist qualified according to section 245I.16, subdivision 2, clause (3), competent in the area of psychological testing; and

(2) be validated in a face-to-face interview between the client and a licensed psychologist or a clinical psychology trainee qualified according to section 245I.16, subdivision 6, under the treatment supervision of a licensed psychologist according to section 245I.18.

(c) The administration, scoring, and interpretation of the psychological tests must be done under the treatment supervision of a licensed psychologist when performed by a technician, psychometrist, or psychological assistant or as part of a computer-assisted psychological testing program. The report resulting from the psychological testing must be signed by the psychologist conducting the face-to-face interview, placed in the client's record, and released to each person authorized by the client.

Sec. 95. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision to read:

Subd. 69. **Psychotherapy.** (a) "Psychotherapy" means treatment of a client with mental illness that applies to the most appropriate psychological, psychiatric, psychosocial, or interpersonal method that conforms to prevailing community standards of professional practice to meet the mental health needs of the client. Medical assistance covers psychotherapy if conducted by a mental health professional qualified according to section 245I.16, subdivision 2, or a clinical trainee qualified according to section 245I.16, subdivision 6.

(b) Individual psychotherapy is psychotherapy designed for one client.

(c) Family psychotherapy is designed for the client and one or more family members or the client's primary caregiver whose participation is necessary to accomplish the client's treatment goals. Family members or primary caregivers participating in a therapy session do not need to be eligible for medical assistance. For purposes of this paragraph, "primary caregiver whose participation is necessary to accomplish the client's treatment goals" excludes shift or facility staff persons at the client's residence. Medical assistance payment for family psychotherapy is limited to face-to-face sessions at which the client is present throughout the family psychotherapy session unless the mental health professional believes the client's absence from the family psychotherapy session is necessary to carry out the client's individual treatment plan. If the client is excluded, the mental health professional must document the reason for and the length of time of the exclusion. The mental health professional must also document any reason a member of the client's family is excluded.

(d) Group psychotherapy is appropriate for a client who, because of the nature of the client's emotional, behavioral, or social dysfunctions, can derive mutual benefit from treatment in a group setting. For a group of three to eight persons, one mental health professional or clinical trainee is required to conduct the group. For a group of nine to 12 persons, a team of at least two mental health professionals or two clinical trainees or one mental health professional and one clinical trainee is required to co-conduct the group. Medical assistance payment is limited to a group of no more than 12 persons.

(e) A multiple-family group psychotherapy session is eligible for medical assistance payment if the psychotherapy session is designed for at least two but not more than five families. Multiple-family group psychotherapy is clearly directed toward meeting the identified treatment needs of each client as indicated in each client's treatment plan. If the client is excluded, the mental health professional or clinical trainee must document the

reason for and the length of time of the exclusion. The mental health professional or clinical trainee must document any reason a member of the client's family is excluded.

Sec. 96. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision to read:

Subd. 70. **Partial hospitalization.** "Partial hospitalization" means a provider's time-limited, structured program of psychotherapy and other therapeutic services, as defined in United States Code, title 42, chapter 7, subchapter XVIII, part E, section 1395x(ff), that is provided in an outpatient hospital facility or community mental health center that meets Medicare requirements to provide partial hospitalization services. Partial hospitalization is a covered service when it is an appropriate alternative to inpatient hospitalization for a client who is experiencing an acute episode of mental illness that meets the criteria for an inpatient hospital admission under Minnesota Rules, part 9505.0520, subpart 1, and who has the family and community resources necessary and appropriate to support the client's residence in the community. Partial hospitalization consists of multiple intensive short-term therapeutic services provided by a multidisciplinary staff person to treat the client's mental illness.

Sec. 97. **[256B.0671] CLIENT ELIGIBILITY FOR MENTAL HEALTH SERVICES.**

Subdivision 1. **Generally.** (a) The provider must use a diagnostic assessment or crisis assessment to determine a client's eligibility for mental health services, except as provided in this section.

(b) Prior to completion of a client's initial diagnostic assessment, a client is eligible for:

(1) one explanation of findings;

(2) one psychological testing;

(3) any combination of individual psychotherapy sessions, family psychotherapy sessions, group psychotherapy sessions, and individual or family psychoeducation sessions not to exceed three sessions; and

(4) crisis assessment and intervention services provided according to section 256B.0624 or 256B.0944.

(c) Based on the needs identified in a crisis assessment as specified in section 256B.0624 or 256B.0944, a client may receive: (1) crisis stabilization services; and (2) any combination of individual psychotherapy sessions, family psychotherapy sessions, or family psychoeducation sessions not to exceed ten sessions within a 12-month period without prior authorization.

(d) Based on the needs identified in a brief diagnostic assessment, a client may receive a combination of individual psychotherapy sessions, family psychotherapy sessions, or family psychoeducation sessions not to exceed ten sessions within a 12-month period without prior authorization for any new client or for an existing client who is projected to need fewer than ten sessions in the next 12 months.

(e) If the amount of services or intensity required by the client exceeds the coverage limits in this section, a provider shall complete a standard diagnostic assessment.

(f) A new standard diagnostic assessment must be completed:

(1) when the client requires services of a greater number or intensity than those permitted by paragraphs (b) to (d);

(2) at least annually following the initial diagnostic assessment if additional services are needed and the client does not meet the criteria for brief assessment.

(3) when the client's mental health condition has changed markedly since the client's most recent diagnostic assessment; or

(4) when the client's current mental health condition does not meet the criteria of the client's current diagnosis.

(g) For an existing client, a new standard diagnostic assessment shall include a written update of the parts where significant new or changed information exists, and documentation where there has not been significant change, including discussion with the client about changes in the client's life situation, functioning, presenting problems, and progress on treatment goals since the last diagnostic assessment was completed.

Subd. 1a. **Continuity of services.** (a) For any client served with a diagnostic assessment completed under Minnesota Rules, parts 9505.0370 to 9505.0372, before the effective date, the diagnostic assessment must be valid for one calendar year after completion.

(b) For any client served with an individual treatment plan completed under section 256B.0622, 256B.0623, 256B.0943, 256B.0946, or 256B.0947 or Minnesota Rules, parts 9505.0370 to 9505.0372, the individual treatment plan must be valid until its expiration date.

(c) This subdivision expires July 1, 2021.

Subd. 2. **Diagnostic assessment.** To be eligible for medical assistance payment, a diagnostic assessment must (1) identify at least one mental health diagnosis and recommend

mental health services to develop the client's mental health services and treatment plan, or (2) include a finding that the client does not meet the criteria for a mental health disorder.

Subd. 3. **Standard diagnostic assessment requirements.** (a) A standard diagnostic assessment must include a face-to-face interview with the client and contain a written evaluation of a client by a mental health professional or clinical trainee. The standard diagnostic assessment must be completed within the cultural context of the client.

(b) The clinician shall gather and document information related to the client's current life situation and the client's:

(1) age;

(2) current living situation, including household membership and housing status;

(3) basic needs status;

(4) education level and employment status;

(5) significant personal relationships, including the client's evaluation of relationship quality;

(6) strengths and resources, including the extent and quality of social networks;

(7) belief systems;

(8) current medications; and

(9) immediate risks to health and safety.

(c) The clinician shall gather and document information related to the elements of the assessment, including the client's:

(1) perceptions of the client's condition;

(2) description of symptoms, including reason for referral;

(3) history of mental health treatment; and

(4) cultural influences and the impact on the client.

(d) A clinician completing a diagnostic assessment shall use professional judgment in making inquiries under this paragraph. If information cannot be obtained without retraumatizing the client or harming the client's willingness to engage in treatment, the clinician shall document which topics require further attention in the course of treatment. A clinician must, as clinically appropriate, include the following information related to a client in a diagnostic assessment:

(1) important developmental incidents;

(2) maltreatment, trauma, potential brain injuries, or abuse issues;

(3) history of alcohol and drug usage and treatment; and

(4) health history and family health history, including physical, chemical, and mental health history.

(e) The clinician must perform and document the following components of the assessment:

(1) the client's mental status examination;

(2) information gathered concerning the client's baseline measurements; symptoms; behavior; skills; abilities; resources; vulnerabilities; safety needs, including client data adequate to support findings based on the current edition of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association; and any differential diagnosis;

(3) for a child younger than 6 years of age, a clinician may use the current edition of the DC: 0-5 Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood instead of the Diagnostic and Statistical Manual of Mental Disorders;

(4) the screenings used to determine the client's substance use, abuse, or dependency and other standardized screening instruments determined by the commissioner;

(5) use of standardized outcome measurements by the provider as determined and periodically updated by the commissioner; and

(6) a case conceptualization that explains: (i) the diagnostic formulation made based on the information gathered through the interview, assessment, available psychological testing, and collateral information; (ii) the needs of the client; (iii) risk factors; (iv) strengths; and (v) responsivity factors.

(f) The diagnostic assessment must include recommendations, client and family participation in assessment and service preferences, and referrals to services required by law.

Subd. 4. **Brief diagnostic assessment requirements.** (a) A brief diagnostic assessment must include a face-to-face interview with the client and a written evaluation of the client by a mental health professional or a clinical trainee. The mental health professional or clinical trainee must gather initial components of a standard diagnostic assessment, including the client's:

(1) age;

(2) description of symptoms, including reason for referral;

(3) history of mental health treatment;

(4) cultural influences and their impact on the client; and

(5) mental status examination.

(b) On the basis of the initial components, the mental health professional or clinical trainee must draw a provisional diagnostic formulation. The diagnostic formulation may be used to address the client's immediate needs or presenting problem.

(c) Treatment sessions conducted under authorization of a brief diagnostic assessment may be used to gather additional information necessary to complete a standard diagnostic assessment if coverage limits in subdivision 1 will be exceeded.

Subd. 5. **Individual treatment plan.** Medical assistance payment is available only for mental health services provided in accordance with the client's written individual treatment plan, with the following exceptions: (1) services that do not require a standard diagnostic assessment prior to service delivery; (2) service plan development; and (3) re-engagement of a client as described in subdivision 6, clause (6).

Subd. 6. **Individual treatment plan; required elements.** An individual treatment plan must:

(1) be based on the information in the client's diagnostic assessment and baselines;

(2) identify goals and objectives of treatment, the treatment strategy, the schedule for accomplishing treatment goals and measurable objectives, and the individuals responsible for providing treatment services and supports;

(3) be developed after completion of the client's diagnostic assessment, within three visits unless otherwise specified by a service line;

(4) for a child client, be developed through a child-centered, family-driven, culturally appropriate planning process, including allowing parents and guardians to observe or participate in individual and family treatment services, assessment, and treatment planning. For an adult client, the individual treatment plan must be developed through a person-centered, culturally appropriate planning process, including allowing identified supports to observe or participate in treatment services, assessment, and treatment planning;

(5) be reviewed at least every 90 days unless otherwise specified by the requirements of a service line and revised to document treatment progress on each treatment objective and next goals or, if progress is not documented, to document changes in treatment; and

(6) be approved by the client, the client's parent, or other person authorized by law to consent to mental health services for the client. If approval cannot be obtained, a mental health professional shall make efforts to obtain approval from an authorized person for a period of 30 days following the date the previous individual treatment plan expired. A client shall not be denied service in this time period solely on the basis of an unapproved individual treatment plan. A provider entity may continue to bill for otherwise eligible services during a period of re-engagement.

Sec. 98. Minnesota Statutes 2018, section 256B.0941, subdivision 1, is amended to read:

Subdivision 1. **Eligibility.** (a) An individual who is eligible for mental health treatment services in a psychiatric residential treatment facility must meet all of the following criteria:

(1) before admission, services are determined to be medically necessary by the state's medical review agent according to Code of Federal Regulations, title 42, section 441.152;

(2) is younger than 21 years of age at the time of admission. Services may continue until the individual meets criteria for discharge or reaches 22 years of age, whichever occurs first;

(3) has a mental health diagnosis as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders, as well as clinical evidence of severe aggression, or a finding that the individual is a risk to self or others;

(4) has functional impairment and a history of difficulty in functioning safely and successfully in the community, school, home, or job; an inability to adequately care for one's physical needs; or caregivers, guardians, or family members are unable to safely fulfill the individual's needs;

(5) requires psychiatric residential treatment under the direction of a physician to improve the individual's condition or prevent further regression so that services will no longer be needed;

(6) utilized and exhausted other community-based mental health services, or clinical evidence indicates that such services cannot provide the level of care needed; and

(7) was referred for treatment in a psychiatric residential treatment facility by a qualified mental health professional licensed as defined in section 245.4871, subdivision 27~~, clauses (1) to (6)~~.

(b) A mental health professional making a referral shall submit documentation to the state's medical review agent containing all information necessary to determine medical necessity, including a standard diagnostic assessment completed within 180 days of the individual's admission. Documentation shall include evidence of family participation in the individual's treatment planning and signed consent for services.

Sec. 99. Minnesota Statutes 2018, section 256B.0943, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** For purposes of this section, the following terms have the meanings given them.

(a) "Children's therapeutic services and supports" means the flexible package of mental health services for children who require varying therapeutic and rehabilitative levels of intervention to treat a diagnosed emotional disturbance~~, as defined in section 245.4871, subdivision 15,~~ or ~~a diagnosed~~ mental illness~~, as defined in section 245.462, subdivision 20~~. The services are time-limited interventions that are delivered using various treatment modalities and combinations of services designed to reach treatment outcomes identified in the individual treatment plan.

~~(b) "Clinical supervision" means the overall responsibility of the mental health professional for the control and direction of individualized treatment planning, service delivery, and treatment review for each client. A mental health professional who is an enrolled Minnesota health care program provider accepts full professional responsibility for a supervisee's actions and decisions, instructs the supervisee in the supervisee's work, and oversees or directs the supervisee's work.~~

~~(c)~~ (b) "Clinical trainee" ~~means a mental health practitioner who meets the qualifications specified in Minnesota Rules, part 9505.0371, subpart 5, item C~~ means a staff person qualified according to section 245I.16, subdivision 6.

~~(d) "Crisis assistance" has the meaning given in section 245.4871, subdivision 9a. Crisis assistance entails the development of a written plan to assist a child's family to contend with a potential crisis and is distinct from the immediate provision of crisis intervention services.~~

(c) "Crisis planning" means the development of a written plan to assist a child's family with a potential crisis and is distinct from the immediate provision of crisis intervention services. The plan addresses prevention and intervention strategies to be used in a crisis.

The plan identifies factors that might precipitate a mental health crisis, behaviors related to the emergence of a crisis, and resources available to resolve a crisis. The plan also must address the following potentialities: (1) arranging for admission to acute care hospital inpatient treatment; (2) crisis placement; (3) community resources for follow-up; and (4) emotional support to the family during crisis.

~~(e)~~ (d) "Culturally competent provider" means a provider who understands and can utilize to a client's benefit the client's culture when providing services to the client. A provider may be culturally competent because the provider is of the same cultural or ethnic group as the client or the provider has developed the knowledge and skills through training and experience to provide services to culturally diverse clients.

~~(f)~~ (e) "Day treatment program" for children means a site-based structured mental health program consisting of psychotherapy for three or more individuals and individual or group skills training provided by a ~~multidisciplinary~~ treatment team, under the ~~clinical~~ treatment supervision of a mental health professional.

~~(g)~~ (f) "Diagnostic assessment" ~~has the meaning given in Minnesota Rules, part 9505.0372, subpart 1~~ means the assessment described under section 256B.0671, subdivisions 2 and 3.

~~(h)~~ (g) "Direct service time" means the time that a mental health professional, clinical trainee, mental health practitioner, or mental health behavioral aide spends face-to-face with a client and the client's family or providing covered telemedicine services. Direct service time includes time in which the provider obtains a client's history, develops a client's treatment plan, records individual treatment outcomes, or provides service components of children's therapeutic services and supports. Direct service time does not include time doing work before and after providing direct services, including scheduling or maintaining clinical records.

~~(i)~~ (h) "Direction of mental health behavioral aide" means the activities of a mental health professional, clinical trainee, or mental health practitioner in guiding the mental health behavioral aide in providing services to a client. The direction of a mental health behavioral aide must be based on the client's individualized treatment plan and meet the requirements in subdivision 6, paragraph (b), clause (5).

~~(j)~~ (i) "Emotional disturbance" has the meaning given in section 245.4871, subdivision 15.

~~(k)~~ (j) "Individual behavioral plan" means a plan of intervention, treatment, and services for a child written by a mental health professional, clinical trainee, or mental health

practitioner, under the ~~clinical~~ treatment supervision of a mental health professional, to guide the work of the mental health behavioral aide. The individual behavioral plan may be incorporated into the child's individual treatment plan so long as the behavioral plan is separately communicable to the mental health behavioral aide.

~~(l)~~ (k) "Individual treatment plan" ~~has the meaning given in Minnesota Rules, part 9505.0371, subpart 7~~ means the plan described under section 256B.0671, subdivisions 5 and 6.

~~(m)~~ (l) "Mental health behavioral aide services" means medically necessary ~~one-on-one~~ activities performed by a trained paraprofessional ~~qualified as provided in subdivision 7, paragraph (b), clause (3),~~ to assist a child retain or generalize psychosocial skills as previously trained by a mental health professional, clinical trainee, or mental health practitioner and as described in the child's individual treatment plan and individual behavior plan. Activities involve working directly with the child or child's family as provided in subdivision 9, paragraph (b), clause (4).

(m) "Mental health certified family peer specialist" means a staff person qualified according to section 245I.16, subdivision 12.

(n) "Mental health practitioner" ~~has the meaning given in~~ means a staff person qualified according to section ~~245.462, subdivision 17, except that a practitioner working in a day treatment setting may qualify as a mental health practitioner if the practitioner holds a bachelor's degree in one of the behavioral sciences or related fields from an accredited college or university, and: (1) has at least 2,000 hours of clinically supervised experience in the delivery of mental health services to clients with mental illness; (2) is fluent in the language, other than English, of the cultural group that makes up at least 50 percent of the practitioner's clients, completes 40 hours of training on the delivery of services to clients with mental illness, and receives clinical supervision from a mental health professional at least once per week until meeting the required 2,000 hours of supervised experience; or (3) receives 40 hours of training on the delivery of services to clients with mental illness within six months of employment, and clinical supervision from a mental health professional at least once per week until meeting the required 2,000 hours of supervised experience~~ 245I.16, subdivision 4.

(o) "Mental health professional" means ~~an individual as defined in Minnesota Rules, part 9505.0370, subpart 18~~ a staff person qualified according to section 245I.16, subdivision 2.

(p) "Mental health service plan development" includes:

(1) the development, review, and revision of a child's individual treatment plan, ~~as provided in Minnesota Rules, part 9505.0371, subpart 7~~ according to section 256B.0671, subdivisions 5 and 6, including involvement of the client or client's parents, primary caregiver, or other person authorized to consent to mental health services for the client, and including arrangement of treatment and support activities specified in the individual treatment plan; and

(2) administering standardized outcome measurement instruments, determined and updated by the commissioner, as periodically needed to evaluate the effectiveness of treatment for children receiving clinical services and reporting outcome measures, as required by the commissioner.

(q) "Mental illness," for persons at least age 18 but under age 21, has the meaning given in section 245.462, subdivision 20, paragraph (a).

(r) "Psychotherapy" means the treatment of mental or emotional disorders or maladjustment by psychological means. Psychotherapy may be provided in many modalities ~~in accordance with Minnesota Rules, part 9505.0372, subpart 6,~~ including patient and/or family psychotherapy; family psychotherapy; psychotherapy for crisis; group psychotherapy; or multiple-family psychotherapy. ~~Beginning with the American Medical Association's Current Procedural Terminology, standard edition, 2014, the procedure "individual psychotherapy" is replaced with "patient and/or family psychotherapy," a substantive change that permits the therapist to work with the client's family without the client present to obtain information about the client or to explain the client's treatment plan to the family.~~ Psychotherapy for crisis is appropriate ~~for crisis response~~ when a child has become dysregulated or experienced new trauma since the diagnostic assessment was completed and needs psychotherapy to address issues not currently included in the child's individual treatment plan.

(s) "Rehabilitative services" or "psychiatric rehabilitation services" means ~~a series or multidisciplinary combination of psychiatric and psychosocial~~ interventions to: (1) restore a child or adolescent to an age-appropriate developmental trajectory that had been disrupted by a psychiatric illness; or (2) enable the child to self-monitor, compensate for, cope with, counteract, or replace psychosocial skills deficits or maladaptive skills acquired over the course of a psychiatric illness. Psychiatric rehabilitation services for children combine coordinated psychotherapy to address internal psychological, emotional, and intellectual processing deficits, and skills training to restore personal and social functioning. Psychiatric rehabilitation services establish a progressive series of goals with each achievement building

upon a prior achievement. ~~Continuing progress toward goals is expected, and rehabilitative potential ceases when successive improvement is not observable over a period of time.~~

(t) "Skills training" means individual, family, or group training, delivered by or under the supervision of a mental health professional, designed to facilitate the acquisition of psychosocial skills that are medically necessary to rehabilitate the child to an age-appropriate developmental trajectory heretofore disrupted by a psychiatric illness or to enable the child to self-monitor, compensate for, cope with, counteract, or replace skills deficits or maladaptive skills acquired over the course of a psychiatric illness. Skills training is subject to the service delivery requirements under subdivision 9, paragraph (b), clause (2).

(u) "Treatment supervision" means the supervision described under section 245I.18.

Sec. 100. Minnesota Statutes 2018, section 256B.0943, subdivision 2, is amended to read:

Subd. 2. **Covered service components of children's therapeutic services and supports.** (a) ~~Subject to federal approval,~~ Medical assistance covers medically necessary children's therapeutic services and supports as defined in this section that an eligible provider entity certified under subdivision 4 provides to a client eligible under subdivision 3.

(b) The service components of children's therapeutic services and supports are:

(1) patient and/or family psychotherapy, family psychotherapy, psychotherapy for crisis, and group psychotherapy;

(2) individual, family, or group skills training provided by a mental health professional or mental health practitioner;

(3) crisis ~~assistance~~ planning;

(4) mental health behavioral aide services;

(5) direction of a mental health behavioral aide;

(6) mental health service plan development; and

(7) children's day treatment.

Sec. 101. Minnesota Statutes 2018, section 256B.0943, subdivision 3, is amended to read:

Subd. 3. **Determination of client eligibility.** A client's eligibility to receive children's therapeutic services and supports under this section shall be determined based on a diagnostic assessment by a mental health professional or ~~a mental health practitioner who meets the requirements of~~ a clinical trainee ~~as defined in Minnesota Rules, part 9505.0371, subpart~~

~~5, item C,~~ that is performed within one year before the initial start of service. The diagnostic assessment must meet the requirements for a standard ~~or extended~~ diagnostic assessment ~~as defined in Minnesota Rules, part 9505.0372, subpart 1, items B and C~~, and:

(1) ~~include current diagnoses, including any differential diagnosis, in accordance with all criteria for a complete diagnosis and diagnostic profile as specified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association, or,~~ for children under age ~~five, as~~ six, follow the requirements specified in the current edition of the Diagnostic Classification of Mental Health Disorders of Infancy and Early Childhood;

(2) determine whether a child under age 18 has a diagnosis of emotional disturbance or, if the person is between the ages of 18 and 21, whether the person has a mental illness;

(3) document children's therapeutic services and supports as medically necessary to address an identified disability, functional impairment, and the individual client's needs and goals; and

(4) be used in the development of the individualized treatment plan~~; and~~.

~~(5) be completed annually until age 18. For individuals between age 18 and 21, unless a client's mental health condition has changed markedly since the client's most recent diagnostic assessment, annual updating is necessary. For the purpose of this section, "updating" means an adult diagnostic update as defined in Minnesota Rules, part 9505.0371, subpart 2, item E.~~

Sec. 102. Minnesota Statutes 2018, section 256B.0943, subdivision 4, is amended to read:

Subd. 4. **Provider entity certification.** (a) The commissioner shall establish an initial provider entity application and certification process and recertification process to determine whether a provider entity has an administrative and clinical infrastructure that meets the requirements in subdivisions 5 and 6. A provider entity must be certified for the three core rehabilitation services of psychotherapy, skills training, and crisis ~~assistance~~ planning. The commissioner shall recertify a provider entity at least every three years. The commissioner shall establish a process for decertification of a provider entity and shall require corrective action, medical assistance repayment, or decertification of a provider entity that no longer meets the requirements in this section or that fails to meet the clinical quality standards or administrative standards provided by the commissioner in the application and certification process.

(b) For purposes of this section, a provider entity must meet all requirements in chapter 245I and be:

(1) an Indian health services facility or a facility owned and operated by a tribe or tribal organization operating as a 638 facility under Public Law 93-638 certified by the state;

(2) a county-operated entity certified by the state; or

(3) a noncounty entity certified by the state.

Sec. 103. Minnesota Statutes 2018, section 256B.0943, subdivision 5, is amended to read:

Subd. 5. **Provider entity administrative infrastructure requirements.** (a) To be an eligible provider entity under this section, a provider entity must have an administrative infrastructure that establishes authority and accountability for decision making and oversight of functions, including finance, personnel, system management, clinical practice, and individual treatment outcomes measurement. An eligible provider entity shall demonstrate the availability, by means of employment or contract, of at least one backup mental health professional in the event of the primary mental health professional's absence. The provider must have written policies and procedures that it reviews and updates every three years and distributes to staff initially and upon each subsequent update.

(b) The administrative infrastructure written policies and procedures must be in accordance with sections 245I.10 and 245I.13 and must include:

(1) personnel procedures, including a process for: (i) recruiting, hiring, training, and retention of culturally and linguistically competent providers; (ii) conducting a criminal background check on all direct service providers and volunteers; (iii) investigating, reporting, and acting on violations of ethical conduct standards; (iv) investigating, reporting, and acting on violations of data privacy policies that are compliant with federal and state laws; (v) utilizing volunteers, including screening applicants, training and supervising volunteers, and providing liability coverage for volunteers; and (vi) documenting that each ~~mental health professional, mental health practitioner, or mental health behavioral aide meets the applicable provider qualification criteria~~ staff person meets the applicable qualifications under section 245I.16, training criteria under ~~subdivision 8~~ section 245I.10, and ~~clinical~~ treatment supervision ~~or direction of a mental health behavioral aide~~ requirements under ~~subdivision 6~~ section 245I.18;

(2) fiscal procedures, including internal fiscal control practices and a process for collecting revenue that is compliant with federal and state laws;

(3) a client-specific treatment outcomes measurement system, including baseline measures, to measure a client's progress toward achieving mental health rehabilitation goals. ~~Effective July 1, 2017,~~ To be eligible for medical assistance payment, a provider entity must

report individual client outcomes to the commissioner, using instruments and protocols approved by the commissioner; and

(4) a process to establish and maintain individual client records in accordance with section 245I.32. ~~The client's records must include:~~

~~(i) the client's personal information;~~

~~(ii) forms applicable to data privacy;~~

~~(iii) the client's diagnostic assessment, updates, results of tests, individual treatment plan, and individual behavior plan, if necessary;~~

~~(iv) documentation of service delivery as specified under subdivision 6;~~

~~(v) telephone contacts;~~

~~(vi) discharge plan; and~~

~~(vii) if applicable, insurance information.~~

(c) A provider entity that uses a restrictive procedure with a client must meet the requirements of section 245.8261.

Sec. 104. Minnesota Statutes 2018, section 256B.0943, subdivision 6, is amended to read:

Subd. 6. **Provider entity clinical infrastructure requirements.** (a) To be an eligible provider entity under this section, a provider entity must have a clinical infrastructure that utilizes diagnostic assessment, individualized treatment plans, service delivery, and individual treatment plan review that are culturally competent, child-centered, and family-driven to achieve maximum benefit for the client. The provider entity must review, and update as necessary, the clinical policies and procedures every three years, must distribute the policies and procedures to staff initially and upon each subsequent update, and must train staff accordingly.

(b) The clinical infrastructure written policies and procedures must include policies and procedures for:

(1) providing or obtaining a client's diagnostic assessment, including a diagnostic assessment performed by an outside or independent clinician, that identifies acute and chronic clinical disorders, co-occurring medical conditions, and sources of psychological and environmental problems, including baselines, and a functional assessment. The functional assessment component must clearly summarize the client's individual strengths and needs. When required components of the diagnostic assessment, such as baseline measures, are

not provided in an outside or independent assessment or when baseline measures cannot be attained in a ~~one-session~~ standard diagnostic assessment, the provider entity must determine the missing information within 30 days and amend the child's diagnostic assessment or incorporate the baselines into the child's individual treatment plan;

(2) developing an individual treatment plan ~~that:~~ according to section 256B.0671, subdivisions 5 and 6;

~~(i) is based on the information in the client's diagnostic assessment and baselines;~~

~~(ii) identified goals and objectives of treatment, treatment strategy, schedule for accomplishing treatment goals and objectives, and the individuals responsible for providing treatment services and supports;~~

~~(iii) is developed after completion of the client's diagnostic assessment by a mental health professional or clinical trainee and before the provision of children's therapeutic services and supports;~~

~~(iv) is developed through a child-centered, family-driven, culturally appropriate planning process, including allowing parents and guardians to observe or participate in individual and family treatment services, assessment, and treatment planning;~~

~~(v) is reviewed at least once every 90 days and revised to document treatment progress on each treatment objective and next goals or, if progress is not documented, to document changes in treatment; and~~

~~(vi) is signed by the clinical supervisor and by the client or by the client's parent or other person authorized by statute to consent to mental health services for the client. A client's parent may approve the client's individual treatment plan by secure electronic signature or by documented oral approval that is later verified by written signature;~~

(3) developing an individual behavior plan that documents ~~treatment strategies~~ and describes interventions to be provided by the mental health behavioral aide. The individual behavior plan must include:

(i) detailed instructions on the ~~treatment strategies to be provided~~ psychosocial skills to be practiced;

(ii) time allocated to each ~~treatment strategy~~ intervention;

(iii) methods of documenting the child's behavior;

(iv) methods of monitoring the child's progress in reaching objectives; and

(v) goals to increase or decrease targeted behavior as identified in the individual treatment plan;

(4) providing ~~clinical~~ treatment supervision plans ~~for mental health practitioners and mental health behavioral aides~~ according to section 245I.18. ~~A mental health professional must document the clinical supervision the professional provides by cosigning individual treatment plans and making entries in the client's record on supervisory activities. The clinical supervisor also shall document supervisee-specific supervision in the supervisee's personnel file. Clinical~~ Treatment supervision does not include the authority to make or terminate court-ordered placements of the child~~. A clinical supervisor must be available for urgent consultation as required by the individual client's needs or the situation. Clinical supervision may occur individually or in a small group to discuss treatment and review progress toward goals. The focus of clinical supervision must be the client's treatment needs and progress and the mental health practitioner's or behavioral aide's ability to provide services~~;

(4a) meeting day treatment program conditions in items (i) to (iii):

(i) the ~~clinical~~ treatment supervisor must be present and available on the premises more than 50 percent of the time in a provider's standard working week during which the supervisee is providing a mental health service;

(ii) the treatment supervisor must review and approve the client's diagnosis and the client's individual treatment plan or a change in the diagnosis or individual treatment plan ~~must be made by or reviewed, approved, and signed by the clinical supervisor~~; and

(iii) every 30 days, the ~~clinical~~ treatment supervisor must review and sign the record indicating the supervisor has reviewed the client's care for all activities in the preceding 30-day period;

(4b) meeting the ~~clinical~~ treatment supervision standards in items (i) ~~to (iv)~~ and (ii) for all other services provided under CTSS:

~~(i) medical assistance shall reimburse for services provided by a mental health practitioner who is delivering services that fall within the scope of the practitioner's practice and who is supervised by a mental health professional who accepts full professional responsibility;~~

~~(ii) medical assistance shall reimburse for services provided by a mental health behavioral aide who is delivering services that fall within the scope of the aide's practice and who is supervised by a mental health professional who accepts full professional responsibility and has an approved plan for clinical supervision of the behavioral aide. Plans must be developed~~

~~in accordance with supervision standards defined in Minnesota Rules, part 9505.0371, subpart 4, items A to D;~~

~~(iii)~~ (i) the mental health professional is required to be present at the site of service delivery for observation as clinically appropriate when the mental health practitioner or mental health behavioral aide is providing CTSS services; and

~~(iv)~~ (ii) when conducted, the on-site presence of the mental health professional must be documented in the child's record and signed by the mental health professional who accepts full professional responsibility;

(5) providing direction to a mental health behavioral aide. For entities that employ mental health behavioral aides, the ~~clinical~~ treatment supervisor must be employed by the provider entity or other provider certified to provide mental health behavioral aide services to ensure necessary and appropriate oversight for the client's treatment and continuity of care. The ~~mental health professional or mental health practitioner~~ staff giving direction must begin with the goals on the individualized treatment plan, and instruct the mental health behavioral aide on how to implement therapeutic activities and interventions that will lead to goal attainment. The ~~professional or practitioner~~ staff giving direction must also instruct the mental health behavioral aide about the client's diagnosis, functional status, and other characteristics that are likely to affect service delivery. Direction must also include determining that the mental health behavioral aide has the skills to interact with the client and the client's family in ways that convey personal and cultural respect and that the aide actively solicits information relevant to treatment from the family. The aide must be able to clearly explain or demonstrate the activities the aide is doing with the client and the activities' relationship to treatment goals. Direction is more didactic than is supervision and requires the ~~professional or practitioner~~ staff providing it to continuously evaluate the mental health behavioral aide's ability to carry out the activities of the individualized treatment plan and the individualized behavior plan. When providing direction, the ~~professional or practitioner~~ staff must:

(i) review progress notes prepared by the mental health behavioral aide for accuracy and consistency with diagnostic assessment, treatment plan, and behavior goals and the professional or practitioner must approve and sign the progress notes;

(ii) identify changes in treatment strategies, revise the individual behavior plan, and communicate treatment instructions and methodologies as appropriate to ensure that treatment is implemented correctly;

(iii) demonstrate family-friendly behaviors that support healthy collaboration among the child, the child's family, and providers as treatment is planned and implemented;

(iv) ensure that the mental health behavioral aide is able to effectively communicate with the child, the child's family, and the provider; and

(v) record the results of any evaluation and corrective actions taken to modify the work of the mental health behavioral aide;

(6) providing service delivery that implements the individual treatment plan and meets the requirements under subdivision 9; and

(7) individual treatment plan review. The review must determine the extent to which the services have met each of the goals and objectives in the treatment plan. The review must assess the client's progress and ensure that services and treatment goals continue to be necessary and appropriate to the client and the client's family or foster family. ~~Revision of the individual treatment plan does not require a new diagnostic assessment unless the client's mental health status has changed markedly. The updated treatment plan must be signed by the clinical supervisor and by the client, if appropriate, and by the client's parent or other person authorized by statute to give consent to the mental health services for the child.~~

Sec. 105. Minnesota Statutes 2018, section 256B.0943, subdivision 7, is amended to read:

Subd. 7. **Qualifications of individual and team providers.** (a) An individual or team provider working within the scope of the provider's practice or qualifications may provide service components of children's therapeutic services and supports that are identified as medically necessary in a client's individual treatment plan.

(b) An individual provider must be qualified as:

(1) a mental health professional ~~as defined in subdivision 1, paragraph (o)~~; ~~or~~

(2) a mental health practitioner or clinical trainee~~. The mental health practitioner or clinical trainee must work under the clinical supervision of a mental health professional~~; ~~or~~

(3) a mental health behavioral aide ~~working under the clinical supervision of a mental health professional to implement the rehabilitative mental health services previously introduced by a mental health professional or practitioner and identified in the client's individual treatment plan and individual behavior plan.~~; or

(4) a mental health certified family peer specialist.

~~(A) A level I mental health behavioral aide must:~~

~~(i) be at least 18 years old;~~

~~(ii) have a high school diploma or commissioner of education-selected high school equivalency certification or two years of experience as a primary caregiver to a child with severe emotional disturbance within the previous ten years; and~~

~~(iii) meet preservice and continuing education requirements under subdivision 8.~~

~~(B) A level II mental health behavioral aide must:~~

~~(i) be at least 18 years old;~~

~~(ii) have an associate or bachelor's degree or 4,000 hours of experience in delivering clinical services in the treatment of mental illness concerning children or adolescents or complete a certificate program established under subdivision 8a; and~~

~~(iii) meet preservice and continuing education requirements in subdivision 8.~~

~~(c) A day treatment multidisciplinary team must include at least one mental health professional or clinical trainee and one mental health practitioner.~~

Sec. 106. Minnesota Statutes 2018, section 256B.0943, subdivision 8, is amended to read:

Subd. 8. **Required preservice and continuing education.** ~~(a)~~ A provider entity shall establish a plan to provide preservice and continuing education for staff according to section 245I.10. ~~The plan must clearly describe the type of training necessary to maintain current skills and obtain new skills and that relates to the provider entity's goals and objectives for services offered.~~

~~(b) A provider that employs a mental health behavioral aide under this section must require the mental health behavioral aide to complete 30 hours of preservice training. The preservice training must include parent team training. The preservice training must include 15 hours of in-person training of a mental health behavioral aide in mental health services delivery and eight hours of parent team training. Curricula for parent team training must be approved in advance by the commissioner. Components of parent team training include:~~

~~(1) partnering with parents;~~

~~(2) fundamentals of family support;~~

~~(3) fundamentals of policy and decision making;~~

~~(4) defining equal partnership;~~

~~(5) complexities of the parent and service provider partnership in multiple service delivery systems due to system strengths and weaknesses;~~

~~(6) sibling impacts;~~

~~(7) support networks; and~~

~~(8) community resources.~~

~~(c) A provider entity that employs a mental health practitioner and a mental health behavioral aide to provide children's therapeutic services and supports under this section must require the mental health practitioner and mental health behavioral aide to complete 20 hours of continuing education every two calendar years. The continuing education must be related to serving the needs of a child with emotional disturbance in the child's home environment and the child's family.~~

~~(d) The provider entity must document the mental health practitioner's or mental health behavioral aide's annual completion of the required continuing education. The documentation must include the date, subject, and number of hours of the continuing education, and attendance records, as verified by the staff member's signature, job title, and the instructor's name. The provider entity must keep documentation for each employee, including records of attendance at professional workshops and conferences, at a central location and in the employee's personnel file.~~

Sec. 107. Minnesota Statutes 2018, section 256B.0943, subdivision 9, is amended to read:

Subd. 9. **Service delivery criteria.** (a) In delivering services under this section, a certified provider entity must ensure that:

(1) ~~each individual provider's caseload size permits the provider to deliver services to both clients with severe, complex needs and clients with less intensive needs.~~ the provider's caseload size ~~should~~ reasonably ~~enable~~ enables the provider to play an active role in service planning, monitoring, and delivering services to meet the client's and client's family's needs, as specified in each client's individual treatment plan;

(2) site-based programs, including day treatment programs, provide staffing and facilities to ensure the client's health, safety, and protection of rights, and that the programs are able to implement each client's individual treatment plan; and

(3) a day treatment program is provided to a group of clients by a ~~multidisciplinary~~ team under the ~~clinical~~ treatment supervision of a mental health professional. The day treatment program must be provided in and by: (i) an outpatient hospital accredited by the Joint Commission on Accreditation of Health Organizations and licensed under sections 144.50 to 144.55; (ii) a community mental health center under section 245.62; or (iii) an entity that is certified under subdivision 4 to operate a program that meets the requirements of section

245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475. The day treatment program must stabilize the client's mental health status while developing and improving the client's independent living and socialization skills. The goal of the day treatment program must be to reduce or relieve the effects of mental illness and provide training to enable the client to live in the community. The program must be available year-round at least three to five days per week, two or three hours per day, unless the normal five-day school week is shortened by a holiday, weather-related cancellation, or other districtwide reduction in a school week. A child transitioning into or out of day treatment must receive a minimum treatment of one day a week for a two-hour time block. The two-hour time block must include at least one hour of patient and/or family or group psychotherapy. The remainder of the structured treatment program may include patient and/or family or group psychotherapy, and individual or group skills training, if included in the client's individual treatment plan. Day treatment programs are not part of inpatient or residential treatment services. When a day treatment group that meets the minimum group size requirement temporarily falls below the minimum group size because of a member's temporary absence, medical assistance covers a group session conducted for the group members in attendance. A day treatment program may provide fewer than the minimally required hours for a particular child during a billing period in which the child is transitioning into, or out of, the program.

(b) To be eligible for medical assistance payment, a provider entity must deliver the service components of children's therapeutic services and supports in compliance with the following requirements:

(1) patient and/or family, family, and group psychotherapy must be delivered as specified in ~~Minnesota Rules, part 9505.0372, subpart 6~~ section 256B.0625, subdivision 69. Psychotherapy to address the child's underlying mental health disorder must be documented as part of the child's ongoing treatment. A provider must deliver, or arrange for, medically necessary psychotherapy, unless the child's parent or caregiver chooses not to receive it. When a provider delivering other services to a child under this section deems it not medically necessary to provide psychotherapy to the child for a period of 90 days or longer, the provider entity must document the medical reasons why psychotherapy is not necessary. When a provider determines that a child needs psychotherapy but psychotherapy cannot be delivered due to a shortage of licensed mental health professionals in the child's community, the provider must document the lack of access in the child's medical record;

(2) individual, family, or group skills training ~~must be provided by a mental health professional or a mental health practitioner who is delivering services that fall within the~~

~~scope of the provider's practice and is supervised by a mental health professional who accepts full professional responsibility for the training. Skills training~~ is subject to the following requirements:

(i) a mental health professional, clinical trainee, or mental health practitioner shall provide skills training;

(ii) skills training delivered to a child or the child's family must be targeted to the specific deficits or maladaptations of the child's mental health disorder and must be prescribed in the child's individual treatment plan;

(iii) the mental health professional delivering or supervising the delivery of skills training must document any underlying psychiatric condition and must document how skills training is being used in conjunction with psychotherapy to address the underlying condition;

(iv) skills training delivered to the child's family must teach skills needed by parents or primary caregivers to enhance the child's skill development, to help the child utilize daily life skills taught by a mental health professional, clinical trainee, or mental health practitioner, and to develop or maintain a home environment that supports the child's progressive use of skills;

(v) group skills training may be provided to multiple recipients who, because of the nature of their emotional, behavioral, or social dysfunction, can derive mutual benefit from interaction in a group setting, which must be staffed as follows:

(A) one mental health professional or one clinical trainee or mental health practitioner ~~under supervision of a licensed mental health professional~~ must work with a group of three to eight clients; or

(B) any combination of two mental health professionals, ~~two~~ clinical trainees, or mental health practitioners ~~under supervision of a licensed mental health professional, or one mental health professional or clinical trainee and one mental health practitioner~~ must work with a group of nine to 12 clients;

(vi) a mental health professional, clinical trainee, or mental health practitioner must have taught the psychosocial skill before a mental health behavioral aide may practice that skill with the client; and

(vii) for group skills training, when a skills group that meets the minimum group size requirement temporarily falls below the minimum group size because of a group member's temporary absence, the provider may conduct the session for the group members in attendance;

(3) crisis ~~assistance~~ planning to a child and family must include development of a written plan that anticipates the particular factors specific to the child that may precipitate a psychiatric crisis for the child in the near future. The written plan must document actions that the family should be prepared to take to resolve or stabilize a crisis, such as advance arrangements for direct intervention and support services to the child and the child's family. Crisis ~~assistance~~ planning must include preparing resources designed to address abrupt or substantial changes in the functioning of the child or the child's family when sudden change in behavior or a loss of usual coping mechanisms is observed, or the child begins to present a danger to self or others;

(4) mental health behavioral aide services must be medically necessary treatment services, identified in the child's individual treatment plan and individual behavior plan, ~~which are performed minimally by a paraprofessional qualified according to subdivision 7, paragraph (b), clause (3), and~~ which are designed to improve the functioning of the child in the progressive use of developmentally appropriate psychosocial skills. Activities involve working directly with the child, child-peer groupings, or child-family groupings to practice, repeat, reintroduce, and master the skills defined in subdivision 1, paragraph (t), as previously taught by a mental health professional, clinical trainee, or mental health practitioner including:

(i) providing cues or prompts in skill-building peer-to-peer or parent-child interactions so that the child progressively recognizes and responds to the cues independently;

(ii) performing as a practice partner or role-play partner;

(iii) reinforcing the child's accomplishments;

(iv) generalizing skill-building activities in the child's multiple natural settings;

(v) assigning further practice activities; and

(vi) intervening as necessary to redirect the child's target behavior and to de-escalate behavior that puts the child or other person at risk of injury.

To be eligible for medical assistance payment, mental health behavioral aide services must be delivered to a child who has been diagnosed with an emotional disturbance or a mental illness, as provided in subdivision 1, paragraph (a). The mental health behavioral aide must implement treatment strategies in the individual treatment plan and the individual behavior plan as developed by the mental health professional, clinical trainee, or mental health practitioner providing direction for the mental health behavioral aide. The mental health behavioral aide must document the delivery of services in written progress notes. Progress

notes must reflect implementation of the treatment strategies, as performed by the mental health behavioral aide and the child's responses to the treatment strategies;

(5) direction of a mental health behavioral aide must include ~~the following:~~

~~(i) ongoing face-to-face observation of the mental health behavioral aide delivering services to a child by a mental health professional or mental health practitioner for at least a total of one hour during every 40 hours of service provided to a child; and~~

~~(ii)~~ immediate accessibility of the mental health professional, clinical trainee, or mental health practitioner to the mental health behavioral aide during service provision; and

(6) mental health service plan development must be performed in consultation with the child's family and, when appropriate, with other key participants in the child's life by the child's treating mental health professional or clinical trainee or by a mental health practitioner and approved by the treating mental health professional. Treatment plan drafting consists of development, review, and revision by face-to-face or electronic communication. The provider must document events, including the time spent with the family and other key participants in the child's life to ~~review, revise, and sign~~ approve the individual treatment plan. ~~Notwithstanding Minnesota Rules, part 9505.0371, subpart 7, medical assistance covers service plan development before completion of the child's individual treatment plan.~~ Service plan development is covered only if a treatment plan is completed for the child. If upon review it is determined that a treatment plan was not completed for the child, the commissioner shall recover the payment for the service plan development~~; and~~.

~~(7) to be eligible for payment, a diagnostic assessment must be complete with regard to all required components, including multiple assessment appointments required for an extended diagnostic assessment and the written report. Dates of the multiple assessment appointments must be noted in the client's clinical record.~~

Sec. 108. Minnesota Statutes 2018, section 256B.0943, subdivision 11, is amended to read:

Subd. 11. **Documentation and billing.** (a) A provider entity must document the services it provides under this section according to section 245I.33. ~~The provider entity must ensure that documentation complies with Minnesota Rules, parts 9505.2175 and 9505.2197. Services billed under this section that are not documented according to this subdivision shall be subject to monetary recovery by the commissioner. Billing for covered service components under subdivision 2, paragraph (b), must not include anything other than direct service time.~~

~~(b) An individual mental health provider must promptly document the following in a client's record after providing services to the client:~~

~~(1) each occurrence of the client's mental health service, including the date, type, start and stop times, scope of the service as described in the child's individual treatment plan, and outcome of the service compared to baselines and objectives;~~

~~(2) the name, dated signature, and credentials of the person who delivered the service;~~

~~(3) contact made with other persons interested in the client, including representatives of the courts, corrections systems, or schools. The provider must document the name and date of each contact;~~

~~(4) any contact made with the client's other mental health providers, case manager, family members, primary caregiver, legal representative, or the reason the provider did not contact the client's family members, primary caregiver, or legal representative, if applicable;~~

~~(5) required clinical supervision directly related to the identified client's services and needs, as appropriate, with co-signatures of the supervisor and supervisee; and~~

~~(6) the date when services are discontinued and reasons for discontinuation of services.~~

Sec. 109. Minnesota Statutes 2018, section 256B.0944, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** For purposes of this section, the following terms have the meanings given them.

(a) "Mental health crisis" means a child's behavioral, emotional, or psychiatric situation that, but for the provision of crisis response services to the child, would likely result in significantly reduced levels of functioning in primary activities of daily living, an emergency situation, or the child's placement in a more restrictive setting, including, but not limited to, inpatient hospitalization.

(b) "Mental health emergency" means a child's behavioral, emotional, or psychiatric situation that causes an immediate need for mental health services and is consistent with section 62Q.55. A physician, mental health professional, or ~~crisis mental health practitioner~~ qualified member of a crisis team determines a mental health crisis or emergency for medical assistance reimbursement with input from the client and the client's family, if possible.

(c) "Mental health crisis assessment" means an immediate face-to-face assessment by a physician, mental health professional, or ~~mental health practitioner under the clinical supervision of a mental health professional~~ qualified member of a crisis team, following a

screening that suggests the child may be experiencing a mental health crisis or mental health emergency situation.

(d) "Mental health mobile crisis intervention services" means face-to-face, short-term intensive mental health services initiated during a mental health crisis or mental health emergency. Mental health mobile crisis services must help the recipient cope with immediate stressors, identify and utilize available resources and strengths, and begin to return to the recipient's baseline level of functioning. Mental health mobile services ~~must be provided on site by a mobile crisis intervention team outside of an emergency room, urgent care, or an inpatient hospital setting.~~, including screening and treatment plan recommendations, must be culturally and linguistically appropriate.

(e) "Mental health crisis stabilization services" means individualized mental health services provided to a recipient following crisis intervention services that are designed to restore the recipient to the recipient's prior functional level. The individual treatment plan recommending mental health crisis stabilization must be completed by the intervention team or by staff after an inpatient or urgent care visit. Mental health crisis stabilization services may be provided in the recipient's home, the home of a family member or friend of the recipient, schools, another community setting, or a short-term supervised, licensed residential program if the service is not included in the facility's cost pool or per diem. Mental health crisis stabilization is not reimbursable when provided as part of a partial hospitalization or day treatment program.

(f) "Clinical trainee" means a person qualified according to section 245I.16, subdivision 6.

(g) "Mental health certified family peer specialist" means a person qualified according to section 245I.16, subdivision 12.

(h) "Mental health practitioner" means a person qualified according to section 245I.16, subdivision 4.

(i) "Mental health professional" means a person qualified according to section 245I.16, subdivision 2.

Sec. 110. Minnesota Statutes 2018, section 256B.0944, subdivision 3, is amended to read:

Subd. 3. **Eligibility.** An eligible recipient is an individual who:

(1) is eligible for medical assistance;

(2) is under age 18 or between the ages of 18 and 21;

(3) is screened as possibly experiencing a mental health crisis or mental health emergency where a mental health crisis assessment is needed; and

(4) is assessed as experiencing a mental health crisis or mental health emergency, and mental health mobile crisis intervention or mental health crisis stabilization services are determined to be medically necessary~~; and~~.

~~(5) meets the criteria for emotional disturbance or mental illness.~~

Sec. 111. Minnesota Statutes 2018, section 256B.0944, subdivision 4, is amended to read:

Subd. 4. **Provider entity standards.** (a) A crisis intervention and crisis stabilization provider entity must meet the administrative and clinical standards specified in section 256B.0943, subdivisions 5 and 6, meet the standards listed in paragraph (b), and be:

(1) an Indian health service facility or facility owned and operated by a tribe or a tribal organization operating under ~~Public Law 93-638 as a 638 facility~~ United States Code, title 25, section 450f;

(2) a county board-operated entity; or

(3) a provider entity that is under contract with the county board in the county where the potential crisis or emergency is occurring.

(b) The children's mental health crisis response services provider entity must:

(1) ensure that mental health crisis assessment and mobile crisis intervention services are available 24 hours a day, seven days a week;

(2) coordinate services with detoxification or withdrawal management services to ensure a recipient receives care that is responsive to the recipient's chemical and mental health needs;

(3) directly provide the services or, if services are subcontracted, the provider entity must maintain clinical responsibility for services and billing;

~~(3)~~ (4) ensure that crisis intervention services are provided in a manner consistent with sections 245.487 to 245.4889; ~~and~~

(5) maintain staff training, documentation, and personnel files, including documentation of staff completion of required training modules according to sections 245I.32 and 245I.33;

(6) establish and maintain a quality assurance and evaluation plan to evaluate the outcomes of services and recipient satisfaction, including notifying recipients of the process by which the county or tribe accepts and responds to concerns;

~~(4)~~ (7) develop and maintain written policies and procedures regarding service provision that include safety of staff and recipients in high-risk situations~~.~~;

(8) respond to a call for crisis services in a designated service area, or according to a written agreement with the local mental health authority for an adjacent area; and

(9) document protocol used when delivering services by telemedicine, according to sections 62A.67 to 62A.672, including responsibilities of the originating site, the means to promote recipient safety, the timelines for connection and response, and the steps to take in the event of a lost connection.

Sec. 112. Minnesota Statutes 2018, section 256B.0944, subdivision 5, is amended to read:

Subd. 5. **Mobile crisis intervention staff qualifications.** ~~(a) To provide children's mental health mobile crisis intervention services, a mobile crisis intervention team must include:~~

~~(1) at least two mental health professionals as defined in section 256B.0943, subdivision 1, paragraph (o); or~~

~~(2) a combination of at least one mental health professional and one mental health practitioner as defined in section 245.4871, subdivision 26, with the required mental health crisis training and under the clinical supervision of a mental health professional on the team.~~

(a) Mobile crisis intervention team staff must be qualified to provide services as mental health professionals, mental health practitioners, clinical trainees, or mental health certified family peer specialists.

(b) A mobile crisis intervention team is comprised of at least two members, one of whom must be qualified as a mental health professional. A second member must be qualified as a mental health professional, clinical trainee, or mental health practitioner. Additional staff must be added to reflect the needs of the area served.

(c) Mental health crisis assessment and intervention services must be led by a mental health professional, or under the supervision of a mental health professional according to subdivision 9, by a clinical trainee or mental health practitioner.

~~(b)~~ (d) The team must have ~~at least two people with~~ at least one member providing on-site crisis intervention services when needed. Team members must be experienced in mental health assessment, crisis intervention techniques, and clinical decision making under emergency conditions and have knowledge of local services and resources. The team must recommend and coordinate the team's services with appropriate local resources, including

the county social services agency, mental health service providers, and local law enforcement, if necessary.

Sec. 113. Minnesota Statutes 2018, section 256B.0944, subdivision 6, is amended to read:

Subd. 6. **Initial screening and crisis assessment planning.** (a) Before initiating mobile crisis intervention services, a screening of the potential crisis situation must be conducted. The screening may use the resources of crisis ~~assistance~~ planning and emergency services as defined in sections 245.4871, subdivision 14, and 245.4879, subdivisions 1 and 2. The screening must gather information, determine whether a crisis situation exists, identify the parties involved, and determine an appropriate response.

(b) In conducting the screening, a provider shall:

(1) employ evidence-based practices as identified by the commissioner in collaboration with the commissioner of health to reduce the risk of the recipient's suicide and self-injurious behavior;

(2) work with the recipient to establish a plan and time frame for responding to the crisis, including immediate needs for support by telephone or text message until a face-to-face response arrives;

(3) document significant factors related to the determination of a crisis, including prior calls to the crisis team, recent presentation at an emergency department, known calls to 911 or law enforcement, or the presence of third parties with knowledge of a potential recipient's history or current needs;

(4) screen for the needs of a third-party caller, including a recipient who primarily identifies as a family member or a caregiver but also presents signs of a crisis; and

(5) provide psychoeducation, including education on the available means for reducing self-harm, to relevant third parties, including family members or other persons living in the home.

(c) A provider entity shall consider the following to indicate a positive screening unless the provider entity documents specific evidence to show why crisis response was clinically inappropriate:

(1) the recipient presented in an emergency department or urgent care setting, and the health care team at that location requested crisis services;

(2) a peace officer requested crisis services for a recipient who may be subject to transportation under section 253B.05 for a mental health crisis.

~~(b)~~ (d) If a crisis exists, a crisis assessment must be completed. A crisis assessment must evaluate any immediate needs for which emergency services are needed and, as time permits, the recipient's current life situation, sources of stress, mental health problems and symptoms, strengths, cultural considerations, support network, vulnerabilities, and current functioning.

~~(c)~~ (e) If the crisis assessment determines mobile crisis intervention services are needed, the intervention services must be provided promptly. As the opportunity presents itself during the intervention, at least two members of the mobile crisis intervention team must confer directly or by telephone about the assessment, treatment plan, and actions taken and needed. At least one of the team members must be on site providing crisis intervention services. If providing on-site crisis intervention services, a mental health practitioner must seek ~~clinical~~ treatment supervision as required under subdivision 9.

(f) Direct contact with the recipient is not required before initiating a crisis assessment or intervention service. A crisis team may gather relevant information from a third party at the scene to establish the need for services and potential safety factors. A crisis assessment is provided face-to-face by a mobile crisis intervention team outside of an inpatient hospital setting. A service must be provided promptly and respond to the recipient's location whenever possible, including community or clinical settings. As clinically appropriate, a mobile crisis intervention team must coordinate a response with other health care providers if a recipient requires detoxification, withdrawal management, or medical stabilization services in addition to crisis services.

~~(d)~~ (g) The mobile crisis intervention team must develop an initial, brief crisis treatment plan as soon as appropriate but no later than 24 hours after the initial face-to-face intervention. The plan must address the needs and problems noted in the crisis assessment and include measurable short-term goals, cultural considerations, and frequency and type of services to be provided to achieve the goals and reduce or eliminate the crisis. The crisis treatment plan must be updated as needed to reflect current goals and services. The team must involve the client and the client's family in developing and implementing the plan.

~~(e)~~ (h) The team must document in progress notes which short-term goals have been met and when no further crisis intervention services are required. If after an assessment a crisis provider entity refers a recipient to an intensive setting, including an emergency department, in-patient hospitalization, or residential treatment, one of the crisis team members who performed or conferred on the assessment must immediately contact the provider entity and consult with the triage nurse or other staff responsible for intake. The crisis team member must convey key findings or concerns that led to the referral. The consultation must occur with the recipient's consent, the recipient's legal guardian's consent, or as allowed by section

144.293, subdivision 5. Any available written documentation, including a crisis treatment plan, must be sent no later than the next business day.

~~(f)~~ (i) If the client's crisis is stabilized, but the client needs a referral for mental health crisis stabilization services or to other services, the team must provide a referral to these services. If the recipient has a case manager, planning for other services must be coordinated with the case manager.

Sec. 114. Minnesota Statutes 2018, section 256B.0944, subdivision 7, is amended to read:

Subd. 7. **Crisis stabilization services.** Crisis stabilization services ~~must be provided by a mental health professional or a mental health practitioner, as defined in section 245.462, subdivision 17, who works under the clinical supervision of a mental health professional and for a crisis stabilization services provider entity and~~ must meet the following standards:

(1) a crisis stabilization treatment plan must be developed which meets the criteria in subdivision 8;

(2) services must be delivered according to the treatment plan and include face-to-face contact with the recipient by qualified staff for further assessment, help with referrals, updating the crisis stabilization treatment plan, supportive counseling, skills training, and collaboration with other service providers in the community; and

(3) staff other than a mental health ~~practitioners~~ professional must have completed at least 30 hours of training in crisis intervention and stabilization during the past two years.

Sec. 115. Minnesota Statutes 2018, section 256B.0944, subdivision 8, is amended to read:

Subd. 8. **Treatment plan.** (a) The individual crisis stabilization treatment plan must include, at a minimum:

(1) a list of problems identified in the assessment;

(2) a list of the recipient's strengths and resources;

(3) concrete, measurable short-term goals and tasks to be achieved, including time frames for achievement of the goals;

(4) specific objectives directed toward the achievement of each goal;

(5) documentation of the participants involved in the service planning;

(6) planned frequency and type of services initiated;

(7) a crisis response action plan if a crisis should occur; and

(8) clear progress notes on the outcome of goals.

(b) The client, if clinically appropriate, must be a participant in the development of the crisis stabilization treatment plan. The client or the client's legal guardian must sign the service plan or documentation must be provided why this was not possible. A copy of the plan must be given to the client and the client's legal guardian. The plan should include services arranged, including specific providers where applicable.

(c) A treatment plan must be developed by a mental health professional, clinical trainee, or mental health practitioner ~~under the clinical supervision of a mental health professional~~. A written plan must be completed within 24 hours of beginning services with the client.

Sec. 116. Minnesota Statutes 2018, section 256B.0944, subdivision 9, is amended to read:

Subd. 9. **Supervision.** ~~(a)~~ A mental health practitioner or clinical trainee may provide crisis assessment and mobile crisis intervention services if the following ~~clinical~~ treatment supervision requirements are met:

(1) the mental health provider entity must accept full responsibility for the services provided;

(2) the mental health professional of the provider entity, who is an employee or under contract with the provider entity, must be immediately available by telephone or in person for ~~clinical~~ treatment supervision;

(3) the mental health professional is consulted, in person or by telephone, during the first three hours when a mental health practitioner provides on-site service; and

(4) the mental health professional must review and approve the tentative crisis assessment and crisis treatment plan, document the consultation, and sign the crisis assessment and treatment plan within the next business day.

~~(b) If the mobile crisis intervention services continue into a second calendar day, a mental health professional must contact the client face-to-face on the second day to provide services and update the crisis treatment plan. The on-site observation must be documented in the client's record and signed by the mental health professional.~~

Sec. 117. Minnesota Statutes 2018, section 256B.0946, subdivision 1, is amended to read:

Subdivision 1. **Required covered service components.** (a) ~~Effective May 23, 2013, and subject to federal approval,~~ Medical assistance covers medically necessary intensive treatment services described under paragraph (b) that are provided by a provider entity

eligible under subdivision 3 to a client eligible under subdivision 2 who is placed in a foster home licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or placed in a foster home licensed under the regulations established by a federally recognized Minnesota tribe.

(b) Intensive treatment services to children with mental illness residing in foster family settings that comprise specific required service components provided in clauses (1) to (5) are reimbursed by medical assistance when they meet the following standards:

(1) psychotherapy provided by a mental health professional ~~as defined in Minnesota Rules, part 9505.0371, subpart 5, item A,~~ or a clinical trainee~~, as defined in Minnesota Rules, part 9505.0371, subpart 5, item C~~;

(2) crisis ~~assistance~~ planning provided according to standards for children's therapeutic services and supports in section 256B.0943;

(3) individual, family, and group psychoeducation services, defined in subdivision 1a, paragraph ~~(q)~~ (o), provided by a mental health professional or a clinical trainee;

(4) clinical care consultation, as defined in subdivision 1a, and provided by a mental health professional or a clinical trainee; and

(5) service delivery payment requirements as provided under subdivision 4.

Sec. 118. Minnesota Statutes 2018, section 256B.0946, subdivision 1a, is amended to read:

Subd. 1a. **Definitions.** For the purposes of this section, the following terms have the meanings given them.

(a) "Clinical care consultation" means communication from a treating clinician to other providers working with the same client to inform, inquire, and instruct regarding the client's symptoms, strategies for effective engagement, care and intervention needs, and treatment expectations across service settings, including but not limited to the client's school, social services, day care, probation, home, primary care, medication prescribers, disabilities services, and other mental health providers and to direct and coordinate clinical service components provided to the client and family.

~~(b) "Clinical supervision" means the documented time a clinical supervisor and supervisee spend together to discuss the supervisee's work, to review individual client cases, and for the supervisee's professional development. It includes the documented oversight and supervision responsibility for planning, implementation, and evaluation of services for a client's mental health treatment.~~

~~(c) "Clinical supervisor" means the mental health professional who is responsible for clinical supervision.~~

~~(d)~~ (b) "Clinical trainee" ~~has the meaning given in Minnesota Rules, part 9505.0371, subpart 5, item C~~ means a staff person qualified according to section 245I.16, subdivision 6;

~~(e)~~ (c) "Crisis ~~assistance~~ planning" has the meaning given in section 245.4871, subdivision 9a, including the development of a plan that addresses prevention and intervention strategies to be used in a potential crisis, but does not include actual crisis intervention.

~~(f)~~ (d) "Culturally appropriate" means providing mental health services in a manner that incorporates the child's cultural influences~~, as defined in Minnesota Rules, part 9505.0370, subpart 9,~~ into interventions as a way to maximize resiliency factors and utilize cultural strengths and resources to promote overall wellness.

~~(g)~~ (e) "Culture" means the distinct ways of living and understanding the world that are used by a group of people and are transmitted from one generation to another or adopted by an individual.

~~(h)~~ (f) "Diagnostic assessment" ~~has the meaning given in Minnesota Rules, part 9505.0370, subpart 11~~ means an assessment described under section 256B.0671, subdivisions 2 and 3.

~~(i)~~ (g) "Family" means a person who is identified by the client or the client's parent or guardian as being important to the client's mental health treatment. Family may include, but is not limited to, parents, foster parents, children, spouse, committed partners, former spouses, persons related by blood or adoption, persons who are a part of the client's permanency plan, or persons who are presently residing together as a family unit.

~~(j)~~ (h) "Foster care" has the meaning given in section 260C.007, subdivision 18.

~~(k)~~ (i) "Foster family setting" means the foster home in which the license holder resides.

~~(l)~~ (j) "Individual treatment plan" ~~has the meaning given in Minnesota Rules, part 9505.0370, subpart 15~~ means the plan described under section 256B.0671, subdivisions 5 and 6.

~~(m) "Mental health practitioner" has the meaning given in section 245.462, subdivision 17, and a mental health practitioner working as a clinical trainee according to Minnesota Rules, part 9505.0371, subpart 5, item C.~~

(k) "Mental health certified family peer specialist" means a staff person qualified according to section 245I.16, subdivision 12.

~~(n)~~ (1) "Mental health professional" ~~has the meaning given in Minnesota Rules, part 9505.0370, subpart 18~~ means a staff person qualified according to section 245I.16, subdivision 2.

~~(o)~~ (m) "Mental illness" has the meaning given in ~~Minnesota Rules, part 9505.0370, subpart 20~~ section 245.462, subdivision 20, paragraph (a), and includes emotional disturbance as defined in section 245.4871, subdivision 15.

~~(p)~~ (n) "Parent" has the meaning given in section 260C.007, subdivision 25.

~~(q)~~ (o) "Psychoeducation services" means information or demonstration provided to an individual, family, or group to explain, educate, and support the individual, family, or group in understanding a child's symptoms of mental illness, the impact on the child's development, and needed components of treatment and skill development so that the individual, family, or group can help the child to prevent relapse, prevent the acquisition of comorbid disorders, and achieve optimal mental health and long-term resilience.

~~(r)~~ (p) "Psychotherapy" has the meaning given in ~~Minnesota Rules, part 9505.0370, subpart 27~~ section 256B.0625, subdivision 69.

~~(s)~~ (q) "Team consultation and treatment planning" means the coordination of treatment plans and consultation among providers in a group concerning the treatment needs of the child, including disseminating the child's treatment service schedule to all members of the service team. Team members must include all mental health professionals working with the child, a parent, the child unless the team lead or parent deem it clinically inappropriate, and at least two of the following: an individualized education program case manager; probation agent; children's mental health case manager; child welfare worker, including adoption or guardianship worker; primary care provider; foster parent; and any other member of the child's service team.

(r) "Trauma" has the meaning given in section 245I.02, subdivision 24.

(s) "Treatment supervision" means the supervision described under section 245I.18.

(t) "Treatment supervisor" means the mental health professional who is responsible for treatment supervision.

Sec. 119. Minnesota Statutes 2018, section 256B.0946, subdivision 2, is amended to read:

Subd. 2. **Determination of client eligibility.** (a) An eligible recipient is an individual, from birth through age 20, who is currently placed in a foster home licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, and has received a diagnostic assessment and an evaluation of level of care needed, as defined in paragraphs ~~(a)~~ (b) and ~~(b)~~ (c).

~~(a)~~ (b) The diagnostic assessment must:

~~(1) meet criteria described in Minnesota Rules, part 9505.0372, subpart 1, and be conducted by a mental health professional or a clinical trainee;~~

~~(2) determine whether or not a child meets the criteria for mental illness, as defined in Minnesota Rules, part 9505.0370, subpart 20;~~

~~(3)~~ (1) document that intensive treatment services are medically necessary within a foster family setting to ameliorate identified symptoms and functional impairments; and

~~(4)~~ (2) be performed within 180 days before the start of service~~; and~~.

~~(5) be completed as either a standard or extended diagnostic assessment annually to determine continued eligibility for the service.~~

~~(b)~~ (c) The evaluation of level of care must be conducted by the placing county, tribe, or case manager in conjunction with the diagnostic assessment ~~as described by Minnesota Rules, part 9505.0372, subpart 1, item B~~, using a validated tool approved by the commissioner of human services and not subject to the rulemaking process, consistent with section 245.4885, subdivision 1, paragraph (d), the result of which evaluation demonstrates that the child requires intensive intervention without 24-hour medical monitoring. The commissioner shall update the list of approved level of care tools annually and publish on the department's website.

Sec. 120. Minnesota Statutes 2018, section 256B.0946, subdivision 3, is amended to read:

Subd. 3. **Eligible mental health services providers.** (a) Eligible providers for intensive children's mental health services in a foster family setting must be certified by the state and have a service provision contract with a county board or a reservation tribal council and must be able to demonstrate the ability to provide all of the services required in this section and meet the requirements under chapter 245I.

(b) For purposes of this section, a provider agency must be:

(1) a county-operated entity certified by the state;

(2) an Indian Health Services facility operated by a tribe or tribal organization under funding authorized by United States Code, title 25, sections 450f to 450n, or title 3 of the Indian Self-Determination Act, Public Law 93-638, section 638 (facilities or providers); or

(3) a noncounty entity.

(c) Certified providers that do not meet the service delivery standards required in this section shall be subject to a decertification process.

(d) For the purposes of this section, all services delivered to a client must be provided by a mental health professional ~~or,~~ a clinical trainee, or a mental health certified family peer specialist.

Sec. 121. Minnesota Statutes 2018, section 256B.0946, subdivision 4, is amended to read:

Subd. 4. **Service delivery payment requirements.** (a) To be eligible for payment under this section, a provider must develop and practice written policies and procedures for intensive treatment in foster care, consistent with subdivision 1, paragraph (b), and comply with the following requirements in paragraphs (b) to ~~(n)~~ (m).

~~(b) A qualified clinical supervisor, as defined in and performing in compliance with Minnesota Rules, part 9505.0371, subpart 5, item D, must supervise the treatment and provision of services described in this section.~~

~~(c) Each client receiving treatment services must receive an extended diagnostic assessment, as described in Minnesota Rules, part 9505.0372, subpart 1, item C, within 30 days of enrollment in this service unless the client has a previous extended diagnostic assessment that the client, parent, and mental health professional agree still accurately describes the client's current mental health functioning.~~

(b) For children under age six, each client must receive a diagnostic assessment according to the requirements in the current edition of the Diagnostic Classification of Mental Health Disorders of Infancy and Early Childhood.

~~(d)~~ (c) Each previous and current mental health, school, and physical health treatment provider must be contacted to request documentation of treatment and assessments that the eligible client has received. This information must be reviewed and incorporated into the diagnostic assessment and team consultation and treatment planning review process.

~~(e)~~ (d) Each client receiving treatment must be assessed for a trauma history, and the client's treatment plan must document how the results of the assessment will be incorporated into treatment.

~~(f)~~ (e) Each client receiving treatment services must have an individual treatment plan that is reviewed, evaluated, and ~~signed~~ approved every 90 days using the team consultation and treatment planning process, as defined in subdivision 1a, paragraph ~~(s)~~ (p).

~~(g)~~ (f) Clinical care consultation, as defined in subdivision 1a, paragraph (a), must be provided in accordance with the client's individual treatment plan.

~~(h)~~ (g) Each client must have a crisis ~~assistance~~ plan within ten days of initiating services and must have access to clinical phone support 24 hours per day, seven days per week, during the course of treatment. The crisis plan must demonstrate coordination with the local or regional mobile crisis intervention team.

~~(i)~~ (h) Services must be delivered and documented at least three days per week, equaling at least six hours of treatment per week, unless reduced units of service are specified on the treatment plan as part of transition or on a discharge plan to another service or level of care. ~~Documentation must comply with Minnesota Rules, parts 9505.2175 and 9505.2197.~~

~~(j)~~ (i) Location of service delivery must be in the client's home, day care setting, school, or other community-based setting that is specified on the client's individualized treatment plan.

~~(k)~~ (j) Treatment must be developmentally and culturally appropriate for the client.

~~(l)~~ (k) Services must be delivered in continual collaboration and consultation with the client's medical providers and, in particular, with prescribers of psychotropic medications, including those prescribed on an off-label basis. Members of the service team must be aware of the medication regimen and potential side effects.

~~(m)~~ (l) Parents, siblings, foster parents, and members of the child's permanency plan must be involved in treatment and service delivery unless otherwise noted in the treatment plan.

~~(n)~~ (m) Transition planning for the child must be conducted starting with the first treatment plan and must be addressed throughout treatment to support the child's permanency plan and postdischarge mental health service needs.

Sec. 122. Minnesota Statutes 2018, section 256B.0946, subdivision 6, is amended to read:

Subd. 6. **Excluded services.** (a) Services in clauses (1) to (7) are not covered under this section and are not eligible for medical assistance payment as components of intensive treatment in foster care services, but may be billed separately:

(1) inpatient psychiatric hospital treatment;

(2) mental health targeted case management;

(3) partial hospitalization;

(4) medication management;

(5) children's mental health day treatment services;

(6) crisis response services under section 256B.0944; and

(7) transportation.

(b) Children receiving intensive treatment in foster care services are not eligible for medical assistance reimbursement for the following services while receiving intensive treatment in foster care:

(1) psychotherapy and skills training components of children's therapeutic services and supports under section 256B.0625, subdivision 35b;

(2) mental health behavioral aide services as defined in section 256B.0943, subdivision 1, paragraph ~~(m)~~ (l);

(3) home and community-based waiver services;

(4) mental health residential treatment; and

(5) room and board costs as defined in section 256I.03, subdivision 6.

Sec. 123. Minnesota Statutes 2018, section 256B.0947, subdivision 1, is amended to read:

Subdivision 1. **Scope.** ~~Effective November 1, 2011, and subject to federal approval,~~ Medical assistance covers medically necessary, intensive nonresidential rehabilitative mental health services as defined in subdivision 2, for recipients as defined in subdivision 3, when the services are provided by an entity meeting the standards in this section.

Sec. 124. Minnesota Statutes 2018, section 256B.0947, subdivision 2, is amended to read:

Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings given them.

(a) "Intensive nonresidential rehabilitative mental health services" means child rehabilitative mental health services as defined in section 256B.0943, except that these services are provided by a multidisciplinary staff using ~~a total team~~ an approach consistent with assertive community treatment, as adapted for youth, and are directed to recipients ~~ages 16, 17, 18, 19, or 20 with a serious mental illness or co-occurring mental illness and substance abuse addiction~~ who require intensive services to prevent admission to an inpatient

psychiatric hospital or placement in a residential treatment facility or who require intensive services to step down from inpatient or residential care to community-based care.

(b) "Co-occurring mental illness and substance abuse addiction" means a dual diagnosis of at least one form of mental illness and at least one substance use disorder. Substance use disorders include alcohol or drug abuse or dependence, excluding nicotine use.

(c) "Diagnostic assessment" ~~has the meaning given to it in Minnesota Rules, part 9505.0370, subpart 11. A diagnostic assessment must be provided according to Minnesota Rules, part 9505.0372, subpart 1,~~ means the assessment described under section 256B.0671, subdivisions 2 and 3, and for this section must incorporate a determination of the youth's necessary level of care using a standardized functional assessment instrument approved and periodically updated by the commissioner.

(d) "Education specialist" means an individual with knowledge and experience working with youth regarding special education requirements and goals, special education plans, and coordination of educational activities with health care activities.

(e) "Housing access support" means an ancillary activity to help an individual find, obtain, retain, and move to safe and adequate housing. Housing access support does not provide monetary assistance for rent, damage deposits, or application fees.

(f) "Integrated dual disorders treatment" means the integrated treatment of co-occurring mental illness and substance use disorders by a team of cross-trained clinicians within the same program, and is characterized by assertive outreach, stage-wise comprehensive treatment, treatment goal setting, and flexibility to work within each stage of treatment.

(g) "Medication education services" means services provided individually or in groups, which focus on:

(1) educating the client and client's family or significant nonfamilial supporters about mental illness and symptoms;

(2) the role and effects of medications in treating symptoms of mental illness; and

(3) the side effects of medications.

Medication education is coordinated with medication management services and does not duplicate it. Medication education services are provided by physicians, pharmacists, or registered nurses with certification in psychiatric and mental health care.

(h) "Peer specialist" means an employed team member who is a mental health certified peer specialist according to section 256B.0615 and also a former children's mental health consumer ~~who:~~.

~~(1) provides direct services to clients including social, emotional, and instrumental support and outreach;~~

~~(2) assists younger peers to identify and achieve specific life goals;~~

~~(3) works directly with clients to promote the client's self-determination, personal responsibility, and empowerment;~~

~~(4) assists youth with mental illness to regain control over their lives and their developmental process in order to move effectively into adulthood;~~

~~(5) provides training and education to other team members, consumer advocacy organizations, and clients on resiliency and peer support; and~~

~~(6) meets the following criteria:~~

~~(i) is at least 22 years of age;~~

~~(ii) has had a diagnosis of mental illness, as defined in Minnesota Rules, part 9505.0370, subpart 20, or co-occurring mental illness and substance abuse addiction;~~

~~(iii) is a former consumer of child and adolescent mental health services, or a former or current consumer of adult mental health services for a period of at least two years;~~

~~(iv) has at least a high school diploma or equivalent;~~

~~(v) has successfully completed training requirements determined and periodically updated by the commissioner;~~

~~(vi) is willing to disclose the individual's own mental health history to team members and clients; and~~

~~(vii) must be free of substance use problems for at least one year.~~

~~(i) "Provider agency" means a for-profit or nonprofit organization established to administer an assertive community treatment for youth team.~~

~~(j)~~ (i) "Substance use disorders" means one or more of the disorders defined in the Diagnostic and Statistical Manual of Mental Disorders, current edition.

~~(k)~~ (j) "Transition services" means:

(1) activities, materials, consultation, and coordination that ensures continuity of the client's care in advance of and in preparation for the client's move from one stage of care or life to another by maintaining contact with the client and assisting the client to establish provider relationships;

(2) providing the client with knowledge and skills needed posttransition;

(3) establishing communication between sending and receiving entities;

(4) supporting a client's request for service authorization and enrollment; and

(5) establishing and enforcing procedures and schedules.

A youth's transition from the children's mental health system and services to the adult mental health system and services and return to the client's home and entry or re-entry into community-based mental health services following discharge from an out-of-home placement or inpatient hospital stay.

~~(l)~~ (k) "Treatment team" means all staff who provide services to recipients under this section.

Sec. 125. Minnesota Statutes 2018, section 256B.0947, subdivision 3, is amended to read:

Subd. 3. **Client eligibility.** An eligible recipient is an individual who:

(1) is age 16, 17, 18, 19, or 20; and

(2) is diagnosed with a serious mental illness or co-occurring mental illness and substance abuse addiction, for which intensive nonresidential rehabilitative mental health services are needed;

(3) has received a level-of-care determination, using an instrument approved by the commissioner, that indicates a need for intensive integrated intervention without 24-hour medical monitoring and a need for extensive collaboration among multiple providers;

(4) has a functional impairment and a history of difficulty in functioning safely and successfully in the community, school, home, or job; or who is likely to need services from the adult mental health system within the next two years; and

(5) has had a recent diagnostic assessment~~, as provided in Minnesota Rules, part 9505.0372, subpart 1, by a mental health professional who is qualified under Minnesota Rules, part 9505.0371, subpart 5, item A,~~ that documents that intensive nonresidential rehabilitative mental health services are medically necessary to ameliorate identified symptoms and functional impairments and to achieve individual transition goals.

Sec. 126. Minnesota Statutes 2018, section 256B.0947, subdivision 3a, is amended to read:

Subd. 3a. **Required service components.** ~~(a) Subject to federal approval, medical assistance covers all medically necessary intensive nonresidential rehabilitative mental health services and supports, as defined in this section, under a single daily rate per client. Services and supports must be delivered by an eligible provider under subdivision 5 to an eligible client under subdivision 3.~~

~~(b)~~ (a) Intensive nonresidential rehabilitative mental health services, supports, and ancillary activities covered by the single daily rate per client must include the following, as needed by the individual client:

(1) individual, family, and group psychotherapy;

(2) individual, family, and group skills training, as defined in section 256B.0943, subdivision 1, paragraph (t);

(3) crisis ~~assistance~~ planning as defined in section ~~245.4871, subdivision 9a, which includes recognition of factors precipitating a mental health crisis, identification of behaviors related to the crisis, and the development of a plan to address prevention, intervention, and follow-up strategies to be used in the lead-up to or onset of, and conclusion of, a mental health crisis; crisis assistance does not mean crisis response services or crisis intervention services provided in section 256B.0944~~ 256B.0943, subdivision 1, paragraph (c);

(4) medication management provided by a physician or an advanced practice registered nurse with certification in psychiatric and mental health care;

(5) mental health case management as provided in section 256B.0625, subdivision 20;

(6) medication education services ~~as defined in this section~~;

(7) care coordination by a client-specific lead worker assigned by and responsible to the treatment team;

(8) psychoeducation of and consultation and coordination with the client's biological, adoptive, or foster family and, in the case of a youth living independently, the client's immediate nonfamilial support network;

(9) clinical consultation to a client's employer or school or to other service agencies or to the courts to assist in managing the mental illness or co-occurring disorder and to develop client support systems;

(10) coordination with, or performance of, crisis intervention and stabilization services as defined in section 256B.0944;

(11) assessment of a client's treatment progress and effectiveness of services using standardized outcome measures published by the commissioner;

(12) transition services as defined in this section;

(13) integrated dual disorders treatment as defined in this section; and

(14) housing access support.

~~(c)~~ (b) The provider shall ensure and document the following by means of performing the required function or by contracting with a qualified person or entity:

(1) client access to crisis intervention services, as defined in section 256B.0944, and available 24 hours per day and seven days per week; and

~~(2) completion of an extended diagnostic assessment, as defined in Minnesota Rules, part 9505.0372, subpart 1, item C; and~~

~~(3)~~ (2) determination of the client's needed level of care using an instrument approved and periodically updated by the commissioner.

Sec. 127. Minnesota Statutes 2018, section 256B.0947, subdivision 5, is amended to read:

Subd. 5. **Standards for intensive nonresidential rehabilitative providers.** (a) Services must be provided by a provider entity as provided in subdivision 4.

(b) The treatment team for intensive nonresidential rehabilitative mental health services comprises both permanently employed core team members and client-specific team members as follows:

(1) ~~The core treatment team is an entity that operates under the direction of an independently licensed mental health professional, who is qualified under Minnesota Rules, part 9505.0371, subpart 5, item A, and that assumes comprehensive clinical responsibility for clients.~~ Based on professional qualifications and client needs, clinically qualified core team members are assigned on a rotating basis as the client's lead worker to coordinate a client's care. The core team must comprise at least four full-time equivalent direct care staff and must include~~, but is not limited to~~ at a minimum:

(i) ~~an independently licensed~~ a mental health professional~~, qualified under Minnesota Rules, part 9505.0371, subpart 5, item A,~~ who serves as team leader to provide administrative direction and ~~clinical~~ treatment supervision to the team;

(ii) an advanced-practice registered nurse with certification in psychiatric or mental health care or a board-certified child and adolescent psychiatrist, either of which must be credentialed to prescribe medications;

(iii) a licensed alcohol and drug counselor who is also trained in mental health interventions; and

(iv) a peer specialist ~~as defined in subdivision 2, paragraph (h)~~.

(2) The core team may also include any of the following:

(i) additional mental health professionals;

(ii) a vocational specialist;

(iii) an educational specialist;

(iv) a child and adolescent psychiatrist who may be retained on a consultant basis;

(v) a mental health practitioner~~, as defined in~~ qualified according to section ~~245.4871, subdivision 26~~ 245I.16, subdivision 4;

(vi) a mental health manager, as defined in section 245.4871, subdivision 4; ~~and~~

(vii) a housing access specialist~~.~~; and

(viii) a clinical trainee qualified according to section 245I.16, subdivision 6.

(3) A treatment team may include, in addition to those in ~~clause~~ clauses (1) ~~or~~ and (2), ad hoc members not employed by the team who consult on a specific client and who must accept overall clinical direction from the treatment team for the duration of the client's placement with the treatment team and must be paid by the provider ~~agency at the rate for a typical session by that provider with that client or at a rate negotiated with the client-specific member~~ entity. Client-specific treatment team members may include:

(i) the mental health professional treating the client prior to placement with the treatment team;

(ii) the client's current substance abuse counselor, if applicable;

(iii) a lead member of the client's individualized education program team or school-based mental health provider, if applicable;

(iv) a representative from the client's health care home or primary care clinic, as needed to ensure integration of medical and behavioral health care;

(v) the client's probation officer or other juvenile justice representative, if applicable; and

(vi) the client's current vocational or employment counselor, if applicable.

(c) The ~~clinical~~ treatment supervisor shall be an active member of the treatment team and shall function as a practicing clinician at least on a part-time basis. The treatment team shall meet with the ~~clinical~~ treatment supervisor at least weekly to discuss recipients' progress and make rapid adjustments to meet recipients' needs. The team meeting must include client-specific case reviews and general treatment discussions among team members. Client-specific case reviews and planning must be documented in the individual client's treatment record.

(d) The staffing ratio must not exceed ten clients to one full-time equivalent treatment team position.

(e) The treatment team shall serve no more than 80 clients at any one time. Should local demand exceed the team's capacity, an additional team must be established rather than exceed this limit.

(f) Nonclinical staff shall have prompt access in person or by telephone to a mental health practitioner or mental health professional. The provider shall have the capacity to promptly and appropriately respond to emergent needs and make any necessary staffing adjustments to assure the health and safety of clients.

(g) The intensive nonresidential rehabilitative mental health services provider shall participate in evaluation of the assertive community treatment for youth (Youth ACT) model as conducted by the commissioner, including the collection and reporting of data and the reporting of performance measures as specified by contract with the commissioner.

(h) A regional treatment team may serve multiple counties.

Sec. 128. Minnesota Statutes 2018, section 256B.0947, subdivision 6, is amended to read:

Subd. 6. **Service standards.** The standards in this subdivision apply to intensive nonresidential rehabilitative mental health services.

(a) The treatment team shall use team treatment, not an individual treatment model.

(b) Services must be available at times that meet client needs.

(c) The initial functional assessment must be completed within ten days of intake and updated at least every three months or prior to discharge from the service, whichever comes first.

(d) An individual treatment plan must be completed for each client, according to criteria specified in section ~~256B.0943, subdivision 6, paragraph (b), clause (2)~~ 256B.0671, subdivisions 5 and 6, and, additionally, must:

(1) be completed in consultation with the client's current therapist and key providers and provide for ongoing consultation with the client's current therapist to ensure therapeutic continuity and to facilitate the client's return to the community;

(2) if a need for substance use disorder treatment is indicated by validated assessment~~:~~,

~~(i)~~ identify goals, objectives, and strategies of substance use disorder treatment; develop a schedule for accomplishing treatment goals and objectives; and identify the individuals responsible for providing treatment services and supports; and

~~(ii) be reviewed at least once every 90 days and revised, if necessary;~~

~~(3) be signed by the clinical supervisor and by the client and, if the client is a minor, by the client's parent or other person authorized by statute to consent to mental health treatment and substance use disorder treatment for the client; and~~

~~(4)~~ (3) provide for the client's transition out of intensive nonresidential rehabilitative mental health services by defining the team's actions to assist the client and subsequent providers in the transition to less intensive or "stepped down" services.

(e) The treatment team shall actively and assertively engage the client's family members and significant others by establishing communication and collaboration with the family and significant others and educating the family and significant others about the client's mental illness, symptom management, and the family's role in treatment, unless the team knows or has reason to suspect that the client has suffered or faces a threat of suffering any physical or mental injury, abuse, or neglect from a family member or significant other.

(f) For a client age 18 or older, the treatment team may disclose to a family member, other relative, or a close personal friend of the client, or other person identified by the client, the protected health information directly relevant to such person's involvement with the client's care, as provided in Code of Federal Regulations, title 45, part 164.502(b). If the client is present, the treatment team shall obtain the client's agreement, provide the client with an opportunity to object, or reasonably infer from the circumstances, based on the exercise of professional judgment, that the client does not object. If the client is not present or is unable, by incapacity or emergency circumstances, to agree or object, the treatment team may, in the exercise of professional judgment, determine whether the disclosure is in the best interests of the client and, if so, disclose only the protected health information that

is directly relevant to the family member's, relative's, friend's, or client-identified person's involvement with the client's health care. The client may orally agree or object to the disclosure and may prohibit or restrict disclosure to specific individuals.

(g) The treatment team shall provide interventions to promote positive interpersonal relationships.

Sec. 129. Minnesota Statutes 2018, section 256B.0947, subdivision 7a, is amended to read:

Subd. 7a. **Noncovered services.** (a) The rate for intensive rehabilitative mental health services does not include medical assistance payment for services in clauses (1) to (7). Services not covered under this paragraph may be billed separately:

(1) inpatient psychiatric hospital treatment;

(2) partial hospitalization;

(3) children's mental health day treatment services;

(4) physician services outside of care provided by a psychiatrist serving as a member of the treatment team;

(5) room and board costs, as defined in section 256I.03, subdivision 6;

(6) home and community-based waiver services; and

(7) other mental health services identified in the child's individualized education program.

(b) The following services are not covered under this section and are not eligible for medical assistance payment while youth are receiving intensive rehabilitative mental health services:

(1) mental health residential treatment; and

(2) mental health behavioral aide services, as defined in section 256B.0943, subdivision 1, paragraph ~~(m)~~ (l).

Sec. 130. Minnesota Statutes 2018, section 256B.0949, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) The terms used in this section have the meanings given in this subdivision.

(b) "Agency" means the legal entity that is enrolled with Minnesota health care programs as a medical assistance provider according to Minnesota Rules, part 9505.0195, to provide EIDBI services and that has the legal responsibility to ensure that its employees or contractors

carry out the responsibilities defined in this section. Agency includes a licensed individual professional who practices independently and acts as an agency.

(c) "Autism spectrum disorder or a related condition" or "ASD or a related condition" means either autism spectrum disorder (ASD) as defined in the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or a condition that is found to be closely related to ASD, as identified under the current version of the DSM, and meets all of the following criteria:

(1) is severe and chronic;

(2) results in impairment of adaptive behavior and function similar to that of a person with ASD;

(3) requires treatment or services similar to those required for a person with ASD; and

(4) results in substantial functional limitations in three core developmental deficits of ASD: social interaction; nonverbal or social communication; and restrictive, repetitive behaviors or hyperreactivity or hyporeactivity to sensory input; and may include deficits or a high level of support in one or more of the following domains:

(i) self-regulation;

(ii) self-care;

(iii) behavioral challenges;

(iv) expressive communication;

(v) receptive communication;

(vi) cognitive functioning; or

(vii) safety.

(d) "Person" means a person under 21 years of age.

(e) "Clinical supervision" means the overall responsibility for the control and direction of EIDBI service delivery, including individual treatment planning, staff supervision, individual treatment plan progress monitoring, and treatment review for each person. Clinical supervision is provided by a qualified supervising professional (QSP) who takes full professional responsibility for the service provided by each supervisee.

(f) "Commissioner" means the commissioner of human services, unless otherwise specified.

(g) "Comprehensive multidisciplinary evaluation" or "CMDE" means a comprehensive evaluation of a person to determine medical necessity for EIDBI services based on the requirements in subdivision 5.

(h) "Department" means the Department of Human Services, unless otherwise specified.

(i) "Early intensive developmental and behavioral intervention benefit" or "EIDBI benefit" means a variety of individualized, intensive treatment modalities approved by the commissioner that are based in behavioral and developmental science consistent with best practices on effectiveness.

(j) "Generalizable goals" means results or gains that are observed during a variety of activities over time with different people, such as providers, family members, other adults, and people, and in different environments including, but not limited to, clinics, homes, schools, and the community.

(k) "Incident" means when any of the following occur:

(1) an illness, accident, or injury that requires first aid treatment;

(2) a bump or blow to the head; or

(3) an unusual or unexpected event that jeopardizes the safety of a person or staff, including a person leaving the agency unattended.

(l) "Individual treatment plan" or "ITP" means the person-centered, individualized written plan of care that integrates and coordinates person and family information from the CMDE for a person who meets medical necessity for the EIDBI benefit. An individual treatment plan must meet the standards in subdivision 6.

(m) "Legal representative" means the parent of a child who is under 18 years of age, a court-appointed guardian, or other representative with legal authority to make decisions about service for a person. For the purpose of this subdivision, "other representative with legal authority to make decisions" includes a health care agent or an attorney-in-fact authorized through a health care directive or power of attorney.

(n) "Mental health professional" has the meaning given in section 245.4871, subdivision 27~~, clauses (1) to (6)~~.

(o) "Person-centered" means a service that both responds to the identified needs, interests, values, preferences, and desired outcomes of the person or the person's legal representative and respects the person's history, dignity, and cultural background and allows inclusion and participation in the person's community.

(p) "Qualified EIDBI provider" means a person who is a QSP or a level I, level II, or level III treatment provider.

Sec. 131. **DIRECTION TO COMMISSIONER; SINGLE COMPREHENSIVE LICENSE STRUCTURE.**

The commissioner of human services, in consultation with counties, tribes, managed care organizations, provider organizations, advocacy groups, and individuals and families served, shall develop recommendations to provide a single comprehensive license structure for mental health service programs, including community mental health centers according to Minnesota Rules, part 9520.0750, intensive residential treatment services, assertive community treatment, adult rehabilitative mental health services, children's therapeutic services and supports, intensive rehabilitative mental health services, intensive treatment in foster care, and children's residential treatment programs currently approved under Minnesota Rules, chapter 2960. The recommendations must prioritize program integrity, the welfare of individuals and families served, improved integration of mental health and substance use disorder services, and the reduction of administrative burden on providers.

Sec. 132. **REPEALER.**

(a) Minnesota Statutes 2018, sections 245.462, subdivision 4a; 256B.0615, subdivisions 2, 4, and 5; 256B.0616, subdivisions 2, 4, and 5; 256B.0943, subdivision 10; 256B.0944, subdivision 10; 256B.0946, subdivision 5; and 256B.0947, subdivision 9, are repealed.

(b) Minnesota Rules, parts 9505.0370; 9505.0371; 9505.0372; 9520.0010; 9520.0020; 9520.0030; 9520.0040; 9520.0050; 9520.0060; 9520.0070; 9520.0080; 9520.0090; 9520.0100; 9520.0110; 9520.0120; 9520.0130; 9520.0140; 9520.0150; 9520.0160; 9520.0170; 9520.0180; 9520.0190; 9520.0200; 9520.0210; and 9520.0230, are repealed.

ARTICLE 8
HEALTH CARE

Section 1. Minnesota Statutes 2018, section 13.69, subdivision 1, is amended to read:

Subdivision 1. **Classifications.** (a) The following government data of the Department of Public Safety are private data:

(1) medical data on driving instructors, licensed drivers, and applicants for parking certificates and special license plates issued to physically disabled persons;

(2) other data on holders of a disability certificate under section 169.345, except that (i) data that are not medical data may be released to law enforcement agencies, and (ii) data necessary for enforcement of sections 169.345 and 169.346 may be released to parking enforcement employees or parking enforcement agents of statutory or home rule charter cities and towns;

(3) Social Security numbers in driver's license and motor vehicle registration records, except that Social Security numbers must be provided to the Department of Revenue for purposes of tax administration, the Department of Labor and Industry for purposes of workers' compensation administration and enforcement, the judicial branch for purposes of debt collection, and the Department of Natural Resources for purposes of license application administration, and except that the last four digits of the Social Security number must be provided to the Department of Human Services for purposes of recovery of Minnesota health care program benefits paid; and

(4) data on persons listed as standby or temporary custodians under section 171.07, subdivision 11, except that the data must be released to:

(i) law enforcement agencies for the purpose of verifying that an individual is a designated caregiver; or

(ii) law enforcement agencies who state that the license holder is unable to communicate at that time and that the information is necessary for notifying the designated caregiver of the need to care for a child of the license holder.

The department may release the Social Security number only as provided in clause (3) and must not sell or otherwise provide individual Social Security numbers or lists of Social Security numbers for any other purpose.

(b) The following government data of the Department of Public Safety are confidential data: data concerning an individual's driving ability when that data is received from a member of the individual's family.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 2. Minnesota Statutes 2018, section 16A.724, subdivision 2, is amended to read:

Subd. 2. **Transfers.** (a) Notwithstanding section 295.581, to the extent available resources in the health care access fund exceed expenditures in that fund, effective for the biennium beginning July 1, 2007, the commissioner of management and budget shall transfer the excess funds from the health care access fund to the general fund on June 30 of each year, provided that the amount transferred in fiscal year 2016 shall not exceed $48,000,000, the

amount in fiscal year 2017 shall not exceed $122,000,000, and the amount in any fiscal biennium thereafter shall not exceed $244,000,000. The purpose of this transfer is to meet the rate increase required under ~~Laws 2003, First Special Session chapter 14, article 13C, section 2, subdivision 6~~ section 256B.688.

(b) For fiscal years 2006 to 2011, MinnesotaCare shall be a forecasted program, and, if necessary, the commissioner shall reduce these transfers from the health care access fund to the general fund to meet annual MinnesotaCare expenditures or, if necessary, transfer sufficient funds from the general fund to the health care access fund to meet annual MinnesotaCare expenditures.

Sec. 3. Minnesota Statutes 2018, section 245A.02, subdivision 5a, is amended to read:

Subd. 5a. **Controlling individual.** (a) "Controlling individual" means an owner of a program or service provider licensed under this chapter and the following individuals, if applicable:

(1) each officer of the organization, including the chief executive officer and chief financial officer;

(2) the individual designated as the authorized agent under section 245A.04, subdivision 1, paragraph (b);

(3) the individual designated as the compliance officer under section 256B.04, subdivision 21, paragraph ~~(b)~~ (g); and

(4) each managerial official whose responsibilities include the direction of the management or policies of a program.

(b) Controlling individual does not include:

(1) a bank, savings bank, trust company, savings association, credit union, industrial loan and thrift company, investment banking firm, or insurance company unless the entity operates a program directly or through a subsidiary;

(2) an individual who is a state or federal official, or state or federal employee, or a member or employee of the governing body of a political subdivision of the state or federal government that operates one or more programs, unless the individual is also an officer, owner, or managerial official of the program, receives remuneration from the program, or owns any of the beneficial interests not excluded in this subdivision;

(3) an individual who owns less than five percent of the outstanding common shares of a corporation:

(i) whose securities are exempt under section 80A.45, clause (6); or

(ii) whose transactions are exempt under section 80A.46, clause (2);

(4) an individual who is a member of an organization exempt from taxation under section 290.05, unless the individual is also an officer, owner, or managerial official of the program or owns any of the beneficial interests not excluded in this subdivision. This clause does not exclude from the definition of controlling individual an organization that is exempt from taxation; or

(5) an employee stock ownership plan trust, or a participant or board member of an employee stock ownership plan, unless the participant or board member is a controlling individual according to paragraph (a).

(c) For purposes of this subdivision, "managerial official" means an individual who has the decision-making authority related to the operation of the program, and the responsibility for the ongoing management of or direction of the policies, services, or employees of the program. A site director who has no ownership interest in the program is not considered to be a managerial official for purposes of this definition.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 4. Minnesota Statutes 2018, section 245D.081, subdivision 3, is amended to read:

Subd. 3. **Program management and oversight.** (a) The license holder must designate a managerial staff person or persons to provide program management and oversight of the services provided by the license holder. The designated manager is responsible for the following:

(1) maintaining a current understanding of the licensing requirements sufficient to ensure compliance throughout the program as identified in section 245A.04, subdivision 1, paragraph (e), and when applicable, as identified in section 256B.04, subdivision 21, paragraph ~~(b)~~ (g);

(2) ensuring the duties of the designated coordinator are fulfilled according to the requirements in subdivision 2;

(3) ensuring the program implements corrective action identified as necessary by the program following review of incident and emergency reports according to the requirements in section 245D.11, subdivision 2, clause (7). An internal review of incident reports of alleged or suspected maltreatment must be conducted according to the requirements in section 245A.65, subdivision 1, paragraph (b);

(4) evaluation of satisfaction of persons served by the program, the person's legal representative, if any, and the case manager, with the service delivery and progress ~~towards~~ toward accomplishing outcomes identified in sections 245D.07 and 245D.071, and ensuring and protecting each person's rights as identified in section 245D.04;

(5) ensuring staff competency requirements are met according to the requirements in section 245D.09, subdivision 3, and ensuring staff orientation and training is provided according to the requirements in section 245D.09, subdivisions 4, 4a, and 5;

(6) ensuring corrective action is taken when ordered by the commissioner and that the terms and conditions of the license and any variances are met; and

(7) evaluating the information identified in clauses (1) to (6) to develop, document, and implement ongoing program improvements.

(b) The designated manager must be competent to perform the duties as required and must minimally meet the education and training requirements identified in subdivision 2, paragraph (b), and have a minimum of three years of supervisory level experience in a program providing direct support services to persons with disabilities or persons age 65 and older.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 5. Minnesota Statutes 2018, section 256.962, subdivision 5, is amended to read:

Subd. 5. **Incentive program.** Beginning January 1, 2008, the commissioner shall establish an incentive program for organizations and licensed insurance producers under chapter 60K that directly identify and assist potential enrollees in filling out and submitting an application. For each applicant who is successfully enrolled in MinnesotaCare or medical assistance, the commissioner, within the available appropriation, shall pay the organization or licensed insurance producer a ~~$25~~ $70 application assistance bonus. The organization or licensed insurance producer may provide an applicant a gift certificate or other incentive upon enrollment.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 6. Minnesota Statutes 2018, section 256.969, subdivision 9, is amended to read:

Subd. 9. **Disproportionate numbers of low-income patients served.** (a) For admissions occurring on or after July 1, 1993, the medical assistance disproportionate population adjustment shall comply with federal law and shall be paid to a hospital, excluding regional treatment centers and facilities of the federal Indian Health Service, with a medical assistance

inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined as follows:

(1) for a hospital with a medical assistance inpatient utilization rate above the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service but less than or equal to one standard deviation above the mean, the adjustment must be determined by multiplying the total of the operating and property payment rates by the difference between the hospital's actual medical assistance inpatient utilization rate and the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service; and

(2) for a hospital with a medical assistance inpatient utilization rate above one standard deviation above the mean, the adjustment must be determined by multiplying the adjustment that would be determined under clause (1) for that hospital by 1.1. The commissioner shall report annually on the number of hospitals likely to receive the adjustment authorized by this paragraph. The commissioner shall specifically report on the adjustments received by public hospitals and public hospital corporations located in cities of the first class.

(b) Certified public expenditures made by Hennepin County Medical Center shall be considered Medicaid disproportionate share hospital payments. Hennepin County and Hennepin County Medical Center shall report by June 15, 2007, on payments made beginning July 1, 2005, or another date specified by the commissioner, that may qualify for reimbursement under federal law. Based on these reports, the commissioner shall apply for federal matching funds.

(c) Upon federal approval of the related state plan amendment, paragraph (b) is effective retroactively from July 1, 2005, or the earliest effective date approved by the Centers for Medicare and Medicaid Services.

(d) Effective July 1, 2015, disproportionate share hospital (DSH) payments shall be paid in accordance with a new methodology using 2012 as the base year. Annual payments made under this paragraph shall equal the total amount of payments made for 2012. A licensed children's hospital shall receive only a single DSH factor for children's hospitals. Other DSH factors may be combined to arrive at a single factor for each hospital that is eligible for DSH payments. The new methodology shall make payments only to hospitals located in Minnesota and include the following factors:

(1) a licensed children's hospital with at least 1,000 fee-for-service discharges in the base year shall receive a factor of 0.868. A licensed children's hospital with less than 1,000 fee-for-service discharges in the base year shall receive a factor of 0.7880;

(2) a hospital that has in effect for the initial rate year a contract with the commissioner to provide extended psychiatric inpatient services under section 256.9693 shall receive a factor of 0.0160;

(3) a hospital that has received payment from the fee-for-service program for at least 20 transplant services in the base year shall receive a factor of 0.0435;

(4) a hospital that has a medical assistance utilization rate in the base year between 20 percent up to one standard deviation above the statewide mean utilization rate shall receive a factor of 0.0468;

(5) a hospital that has a medical assistance utilization rate in the base year that is at least one standard deviation above the statewide mean utilization rate but is less than three standard deviations above the mean shall receive a factor of 0.2300; and

(6) a hospital that has a medical assistance utilization rate in the base year that is at least three standard deviations above the statewide mean utilization rate shall receive a factor of 0.3711.

(e) Any payments or portion of payments made to a hospital under this subdivision that are subsequently returned to the commissioner because the payments are found to exceed the hospital-specific DSH limit for that hospital shall be redistributed, proportionate to the number of fee-for-service discharges, to other DSH-eligible non-children's hospitals that have a medical assistance utilization rate that is at least one standard deviation above the mean.

(f) An additional payment adjustment shall be established by the commissioner under this subdivision for a hospital that provides high levels of administering high-cost drugs to enrollees in fee-for-service medical assistance. The commissioner shall consider factors including fee-for-service medical assistance utilization rates and payments made for drugs purchased through the 340B drug purchasing program and administered to fee-for-service enrollees. If any part of this adjustment exceeds a hospital's hospital-specific disproportionate share hospital limit, the commissioner shall make a payment to the hospital that equals the nonfederal share of the amount that exceeds the limit. The total nonfederal share of the amount of the payment adjustment under this paragraph shall not exceed $1,500,000.

EFFECTIVE DATE. This section is effective for discharges on or after April 1, 2019.

Sec. 7. Minnesota Statutes 2018, section 256B.04, subdivision 21, is amended to read:

Subd. 21. **Provider enrollment.** (a) The commissioner shall enroll providers and conduct screening activities as required by Code of Federal Regulations, title 42, section 455, subpart

E. A provider providing services from multiple locations must enroll each location separately. The commissioner may deny a provider's incomplete application if a provider fails to respond to the commissioner's request for additional information within 60 days of the request. The commissioner must conduct a background study under chapter 245C, including a review of databases in section 245C.08, subdivision 1, paragraph (a), clauses (1) to (5), for a provider described in this paragraph. The background study requirement may be satisfied if the commissioner conducted a fingerprint-based background study on the provider that includes a review of databases in section 245C.08, subdivision 1, paragraph (a), clauses (1) to (5).

(b) The commissioner shall revalidate each: (1) provider under this subdivision at least once every five years; and (2) personal care assistance agency under this subdivision once every three years.

(c) The commissioner shall conduct revalidation as follows:

(1) provide 30-day notice of the revalidation due date including instructions for revalidation and a list of materials the provider must submit;

(2) if a provider fails to submit all required materials by the due date, notify the provider of the deficiency within 30 days after the due date and allow the provider an additional 30 days from the notification date to comply; and

(3) if a provider fails to remedy a deficiency within the 30-day time period, give 60-day notice of termination and immediately suspend the provider's ability to bill. The provider does not have the right to appeal suspension of ability to bill.

(d) If a provider fails to comply with any individual provider requirement or condition of participation, the commissioner may suspend the provider's ability to bill until the provider comes into compliance. The commissioner's decision to suspend the provider is not subject to an administrative appeal.

(e) All correspondence and notifications, including notifications of termination and other actions, must be delivered electronically to a provider's MN-ITS mailbox. For a provider that does not have a MN-ITS account and mailbox, notice must be sent by first-class mail. This paragraph does not apply to correspondences and notifications related to background studies.

(f) If the commissioner or the Centers for Medicare and Medicaid Services determines that a provider is designated "high-risk," the commissioner may withhold payment from providers within that category upon initial enrollment for a 90-day period. The withholding for each provider must begin on the date of the first submission of a claim.

~~(b)~~ (g) An enrolled provider that is also licensed by the commissioner under chapter 245A, or is licensed as a home care provider by the Department of Health under chapter 144A and has a home and community-based services designation on the home care license under section 144A.484, must designate an individual as the entity's compliance officer. The compliance officer must:

(1) develop policies and procedures to assure adherence to medical assistance laws and regulations and to prevent inappropriate claims submissions;

(2) train the employees of the provider entity, and any agents or subcontractors of the provider entity including billers, on the policies and procedures under clause (1);

(3) respond to allegations of improper conduct related to the provision or billing of medical assistance services, and implement action to remediate any resulting problems;

(4) use evaluation techniques to monitor compliance with medical assistance laws and regulations;

(5) promptly report to the commissioner any identified violations of medical assistance laws or regulations; and

(6) within 60 days of discovery by the provider of a medical assistance reimbursement overpayment, report the overpayment to the commissioner and make arrangements with the commissioner for the commissioner's recovery of the overpayment.

The commissioner may require, as a condition of enrollment in medical assistance, that a provider within a particular industry sector or category establish a compliance program that contains the core elements established by the Centers for Medicare and Medicaid Services.

~~(c)~~ (h) The commissioner may revoke the enrollment of an ordering or rendering provider for a period of not more than one year, if the provider fails to maintain and, upon request from the commissioner, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services written or ordered by such provider, when the commissioner has identified a pattern of a lack of documentation. A pattern means a failure to maintain documentation or provide access to documentation on more than one occasion. Nothing in this paragraph limits the authority of the commissioner to sanction a provider under the provisions of section 256B.064.

~~(d)~~ (i) The commissioner shall terminate or deny the enrollment of any individual or entity if the individual or entity has been terminated from participation in Medicare or under the Medicaid program or Children's Health Insurance Program of any other state.

~~(e)~~ (j) As a condition of enrollment in medical assistance, the commissioner shall require that a provider designated "moderate" or "high-risk" by the Centers for Medicare and Medicaid Services or the commissioner permit the Centers for Medicare and Medicaid Services, its agents, or its designated contractors and the state agency, its agents, or its designated contractors to conduct unannounced on-site inspections of any provider location. The commissioner shall publish in the Minnesota Health Care Program Provider Manual a list of provider types designated "limited," "moderate," or "high-risk," based on the criteria and standards used to designate Medicare providers in Code of Federal Regulations, title 42, section 424.518. The list and criteria are not subject to the requirements of chapter 14. The commissioner's designations are not subject to administrative appeal.

~~(f)~~ (k) As a condition of enrollment in medical assistance, the commissioner shall require that a high-risk provider, or a person with a direct or indirect ownership interest in the provider of five percent or higher, consent to criminal background checks, including fingerprinting, when required to do so under state law or by a determination by the commissioner or the Centers for Medicare and Medicaid Services that a provider is designated high-risk for fraud, waste, or abuse.

~~(g)~~ (l)(1) Upon initial enrollment, reenrollment, and notification of revalidation, all durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) medical suppliers meeting the durable medical equipment provider and supplier definition in clause (3), operating in Minnesota and receiving Medicaid funds must purchase a surety bond that is annually renewed and designates the Minnesota Department of Human Services as the obligee, and must be submitted in a form approved by the commissioner. For purposes of this clause, the following medical suppliers are not required to obtain a surety bond: a federally qualified health center, a home health agency, the Indian Health Service, a pharmacy, and a rural health clinic.

(2) At the time of initial enrollment or reenrollment, durable medical equipment providers and suppliers defined in clause (3) must purchase a surety bond of $50,000. If a revalidating provider's Medicaid revenue in the previous calendar year is up to and including $300,000, the provider agency must purchase a surety bond of $50,000. If a revalidating provider's Medicaid revenue in the previous calendar year is over $300,000, the provider agency must purchase a surety bond of $100,000. The surety bond must allow for recovery of costs and fees in pursuing a claim on the bond.

(3) "Durable medical equipment provider or supplier" means a medical supplier that can purchase medical equipment or supplies for sale or rental to the general public and is able

to perform or arrange for necessary repairs to and maintenance of equipment offered for sale or rental.

~~(h)~~ (m) The Department of Human Services may require a provider to purchase a surety bond as a condition of initial enrollment, reenrollment, reinstatement, or continued enrollment if: (1) the provider fails to demonstrate financial viability, (2) the department determines there is significant evidence of or potential for fraud and abuse by the provider, or (3) the provider or category of providers is designated high-risk pursuant to paragraph ~~(a)~~ (f) and as per Code of Federal Regulations, title 42, section 455.450. The surety bond must be in an amount of $100,000 or ten percent of the provider's payments from Medicaid during the immediately preceding 12 months, whichever is greater. The surety bond must name the Department of Human Services as an obligee and must allow for recovery of costs and fees in pursuing a claim on the bond. This paragraph does not apply if the provider currently maintains a surety bond under the requirements in section 256B.0659 or 256B.85.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 8. Minnesota Statutes 2018, section 256B.04, subdivision 22, is amended to read:

Subd. 22. **Application fee.** (a) The commissioner must collect and retain federally required nonrefundable application fees to pay for provider screening activities in accordance with Code of Federal Regulations, title 42, section 455, subpart E. The enrollment application must be made under the procedures specified by the commissioner, in the form specified by the commissioner, and accompanied by an application fee described in paragraph (b), or a request for a hardship exception as described in the specified procedures. Application fees must be deposited in the provider screening account in the special revenue fund. Amounts in the provider screening account are appropriated to the commissioner for costs associated with the provider screening activities required in Code of Federal Regulations, title 42, section 455, subpart E. ~~The commissioner shall conduct screening activities as required by Code of Federal Regulations, title 42, section 455, subpart E, and as otherwise provided by law, to include database checks, unannounced pre- and postenrollment site visits, fingerprinting, and criminal background studies. The commissioner must revalidate all providers under this subdivision at least once every five years.~~

(b) The application fee under this subdivision is $532 for the calendar year 2013. For calendar year 2014 and subsequent years, the fee:

(1) is adjusted by the percentage change to the Consumer Price Index for all urban consumers, United States city average, for the 12-month period ending with June of the previous year. The resulting fee must be announced in the Federal Register;

(2) is effective from January 1 to December 31 of a calendar year;

(3) is required on the submission of an initial application, an application to establish a new practice location, an application for reenrollment when the provider is not enrolled at the time of application of reenrollment, or at revalidation when required by federal regulation; and

(4) must be in the amount in effect for the calendar year during which the application for enrollment, new practice location, or reenrollment is being submitted.

(c) The application fee under this subdivision cannot be charged to:

(1) providers who are enrolled in Medicare or who provide documentation of payment of the fee to, and enrollment with, another state, unless the commissioner is required to rescreen the provider;

(2) providers who are enrolled but are required to submit new applications for purposes of reenrollment;

(3) a provider who enrolls as an individual; and

(4) group practices and clinics that bill on behalf of individually enrolled providers within the practice who have reassigned their billing privileges to the group practice or clinic.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 9. Minnesota Statutes 2018, section 256B.055, subdivision 2, is amended to read:

Subd. 2. **Subsidized foster children.** Medical assistance may be paid for a child eligible for or receiving foster care maintenance payments under Title IV-E of the Social Security Act, United States Code, title 42, sections 670 to 676, and for a child who is not eligible for Title IV-E of the Social Security Act but who is determined eligible for foster care or kinship assistance under chapter 256N.

EFFECTIVE DATE. This section is effective January 1, 2020, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 10. Minnesota Statutes 2018, section 256B.056, subdivision 3, is amended to read:

Subd. 3. **Asset limitations for certain individuals.** (a) To be eligible for medical assistance, a person must not individually own more than $3,000 in assets, or if a member of a household with two family members, husband and wife, or parent and child, the

household must not own more than $6,000 in assets, plus $200 for each additional legal dependent. In addition to these maximum amounts, an eligible individual or family may accrue interest on these amounts, but they must be reduced to the maximum at the time of an eligibility redetermination. The accumulation of the clothing and personal needs allowance according to section 256B.35 must also be reduced to the maximum at the time of the eligibility redetermination. The value of assets that are not considered in determining eligibility for medical assistance is the value of those assets excluded under the Supplemental Security Income program for aged, blind, and disabled persons, with the following exceptions:

(1) household goods and personal effects are not considered;

(2) capital and operating assets of a trade or business that the local agency determines are necessary to the person's ability to earn an income are not considered;

(3) motor vehicles are excluded to the same extent excluded by the Supplemental Security Income program;

(4) assets designated as burial expenses are excluded to the same extent excluded by the Supplemental Security Income program. Burial expenses funded by annuity contracts or life insurance policies must irrevocably designate the individual's estate as contingent beneficiary to the extent proceeds are not used for payment of selected burial expenses;

(5) for a person who no longer qualifies as an employed person with a disability due to loss of earnings, assets allowed while eligible for medical assistance under section 256B.057, subdivision 9, are not considered for 12 months, beginning with the first month of ineligibility as an employed person with a disability, to the extent that the person's total assets remain within the allowed limits of section 256B.057, subdivision 9, paragraph (d);

(6) ~~when a person enrolled in medical assistance under section 256B.057, subdivision 9, is age 65 or older and has been enrolled during each of the 24 consecutive months before the person's 65th birthday, the assets owned by the person and the person's spouse must be disregarded, up to the limits of section 256B.057, subdivision 9, paragraph (d), when determining eligibility for medical assistance under section 256B.055, subdivision 7.~~ a designated employment incentives asset account is disregarded when determining eligibility for medical assistance for a person age 65 years or older under section 256B.055, subdivision 7. An employment incentives asset account must only be designated by a person who has been enrolled in medical assistance under section 256B.057, subdivision 9, for a 24-consecutive-month period. A designated employment incentives asset account contains qualified assets owned by the person and the person's spouse in the last month of enrollment

in medical assistance under section 256B.057, subdivision 9. Qualified assets include retirement and pension accounts, medical expense accounts, and up to $17,000 of the person's other nonexcluded assets. An employment incentives asset account is no longer designated when a person loses medical assistance eligibility for a calendar month or more before turning age 65. A person who loses medical assistance eligibility before age 65 can establish a new designated employment incentives asset account by establishing a new 24-consecutive-month period of enrollment under section 256B.057, subdivision 9. The income of a spouse of a person enrolled in medical assistance under section 256B.057, subdivision 9, during each of the 24 consecutive months before the person's 65th birthday must be disregarded when determining eligibility for medical assistance under section 256B.055, subdivision 7. Persons eligible under this clause are not subject to the provisions in section 256B.059; and

(7) effective July 1, 2009, certain assets owned by American Indians are excluded as required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public Law 111-5. For purposes of this clause, an American Indian is any person who meets the definition of Indian according to Code of Federal Regulations, title 42, section 447.50.

(b) No asset limit shall apply to persons eligible under section 256B.055, subdivision 15.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 11. Minnesota Statutes 2018, section 256B.0625, subdivision 13, is amended to read:

Subd. 13. **Drugs.** (a) Medical assistance covers drugs, except for fertility drugs when specifically used to enhance fertility, if prescribed by a licensed practitioner and dispensed by a licensed pharmacist, by a physician enrolled in the medical assistance program as a dispensing physician, or by a physician, physician assistant, or a nurse practitioner employed by or under contract with a community health board as defined in section 145A.02, subdivision 5, for the purposes of communicable disease control.

(b) The dispensed quantity of a prescription drug must not exceed a 34-day supply, unless authorized by the commissioner.

(c) For the purpose of this subdivision and subdivision 13d, an "active pharmaceutical ingredient" is defined as a substance that is represented for use in a drug and when used in the manufacturing, processing, or packaging of a drug becomes an active ingredient of the drug product. An "excipient" is defined as an inert substance used as a diluent or vehicle for a drug. The commissioner shall establish a list of active pharmaceutical ingredients and

excipients which are included in the medical assistance formulary. Medical assistance covers selected active pharmaceutical ingredients and excipients used in compounded prescriptions when the compounded combination is specifically approved by the commissioner or when a commercially available product:

(1) is not a therapeutic option for the patient;

(2) does not exist in the same combination of active ingredients in the same strengths as the compounded prescription; and

(3) cannot be used in place of the active pharmaceutical ingredient in the compounded prescription.

(d) Medical assistance covers the following over-the-counter drugs when prescribed by a licensed practitioner or by a licensed pharmacist who meets standards established by the commissioner, in consultation with the board of pharmacy: antacids, acetaminophen, family planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults with documented vitamin deficiencies, vitamins for children under the age of seven and pregnant or nursing women, and any other over-the-counter drug identified by the commissioner, in consultation with the Formulary Committee, as necessary, appropriate, and cost-effective for the treatment of certain specified chronic diseases, conditions, or disorders, and this determination shall not be subject to the requirements of chapter 14. A pharmacist may prescribe over-the-counter medications as provided under this paragraph for purposes of receiving reimbursement under Medicaid. When prescribing over-the-counter drugs under this paragraph, licensed pharmacists must consult with the recipient to determine necessity, provide drug counseling, review drug therapy for potential adverse interactions, and make referrals as needed to other health care professionals. ~~Over-the-counter medications must be dispensed in a quantity that is the lowest of: (1) the number of dosage units contained in the manufacturer's original package; (2) the number of dosage units required to complete the patient's course of therapy; or (3) if applicable, the number of dosage units dispensed from a system using retrospective billing, as provided under subdivision 13e, paragraph (b).~~

(e) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible for drug coverage as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A). For these individuals, medical assistance may cover drugs from the drug classes listed in United States

Code, title 42, section 1396r-8(d)(2), subject to this subdivision and subdivisions 13a to 13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall not be covered.

(f) Medical assistance covers drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B covered entities and ambulatory pharmacies under common ownership of the 340B covered entity. Medical assistance does not cover drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B contract pharmacies.

EFFECTIVE DATE. This section is effective April 1, 2019, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 12. Minnesota Statutes 2018, section 256B.0625, subdivision 13e, is amended to read:

Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall be the lower of the ~~actual acquisition~~ ingredient costs of the drugs ~~or the maximum allowable cost by the commissioner~~ plus the ~~fixed~~ professional dispensing fee; or the usual and customary price charged to the public. The usual and customary price means the lowest price charged by the provider to a patient who pays for the prescription by cash, check, or charge account and includes prices the pharmacy charges to a patient enrolled in a prescription savings club or prescription discount club administered by the pharmacy or pharmacy chain. The amount of payment basis must be reduced to reflect all discount amounts applied to the charge by any third-party provider/insurer agreement or contract for submitted charges to medical assistance programs. The net submitted charge may not be greater than the patient liability for the service. The ~~pharmacy~~ professional dispensing fee shall be ~~$3.65~~ $10.48 for ~~legend prescription drugs, except that~~ prescriptions filled with legend drugs meeting the definition of "covered outpatient drugs" according to United States Code, title 42, section 1396r-8(k)(2). The dispensing fee for intravenous solutions ~~which~~ that must be compounded by the pharmacist shall be ~~$8~~ $10.48 per bag~~, $14 per bag for cancer chemotherapy products, and $30 per bag for total parenteral nutritional products dispensed in one liter quantities, or $44 per bag for total parenteral nutritional products dispensed in quantities greater than one liter~~. The professional dispensing fee for prescriptions filled with over-the-counter drugs meeting the definition of covered outpatient drugs shall be $10.48 for dispensed quantities equal to or greater than the number of units contained in the manufacturer's original package. The professional dispensing fee shall be prorated based on the percentage of the package dispensed when the pharmacy dispenses

a quantity less than the number of units contained in the manufacturer's original package. The pharmacy dispensing fee for prescribed over-the-counter drugs not meeting the definition of covered outpatient drugs shall be $3.65~~, except that the fee shall be $1.31 for retrospectively billing pharmacies when billing for quantities less than the number of units contained in the manufacturer's original package. Actual acquisition cost includes quantity and other special discounts except time and cash discounts. The actual acquisition cost of a drug shall be estimated by the commissioner at wholesale acquisition cost plus four percent for independently owned pharmacies located in a designated rural area within Minnesota, and at wholesale acquisition cost plus two percent for all other pharmacies. A pharmacy is "independently owned" if it is one of four or fewer pharmacies under the same ownership nationally. A "designated rural area" means an area defined as a small rural area or isolated rural area according to the four-category classification of the Rural Urban Commuting Area system developed for the United States Health Resources and Services Administration. Effective January 1, 2014, the actual acquisition~~ for quantities equal to or greater than the number of units contained in the manufacturer's original package and shall be prorated based on the percentage of the package dispensed when the pharmacy dispenses a quantity less than the number of units contained in the manufacturer's original package. The ingredient cost of a drug ~~acquired through~~ for a provider participating in the federal 340B Drug Pricing Program shall be ~~estimated by the commissioner at wholesale acquisition cost minus 40 percent~~ either the 340B Drug Pricing Program ceiling price established by the Health Resources and Services Administration or the National Average Drug Acquisition Cost (NADAC), whichever is lower. Wholesale acquisition cost is defined as the manufacturer's list price for a drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates, or reductions in price, for the most recent month for which information is available, as reported in wholesale price guides or other publications of drug or biological pricing data. The maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to~~, but~~ the actual acquisition cost of the drug product and no higher than~~, the maximum amount paid by other third-party payors in this state who have maximum allowable cost programs~~ the NADAC of the generic product. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act.

(b) Pharmacies dispensing prescriptions to residents of long-term care facilities using an automated drug distribution system meeting the requirements of section 151.58, or a packaging system meeting the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse, may employ retrospective billing for prescription drugs dispensed to long-term care facility residents. A

retrospectively billing pharmacy must submit a claim only for the quantity of medication used by the enrolled recipient during the defined billing period. A retrospectively billing pharmacy must use a billing period not less than one calendar month or 30 days.

(c) ~~An additional dispensing fee of $.30 may be added to the dispensing fee paid to pharmacists for legend drug prescriptions dispensed to residents of long-term care facilities when a unit dose blister card system, approved by the department, is used. Under this type of dispensing system, the pharmacist must dispense a 30-day supply of drug. The National Drug Code (NDC) from the drug container used to fill the blister card must be identified on the claim to the department. The unit dose blister card containing the drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse.~~ A pharmacy provider using packaging that meets the standards set forth in Minnesota Rules, part 6800.2700, is required to credit the department for the actual acquisition cost of all unused drugs that are eligible for reuse, unless the pharmacy is using retrospective billing. The commissioner may permit the drug clozapine to be dispensed in a quantity that is less than a 30-day supply.

(d) ~~Whenever a maximum allowable cost has been set for~~ If a pharmacy dispenses a multisource drug, ~~payment shall be the lower of the usual and customary price charged to the public or~~ the ingredient cost shall be the NADAC of the generic product or the maximum allowable cost established by the commissioner unless prior authorization for the brand name product has been granted according to the criteria established by the Drug Formulary Committee as required by subdivision 13f, paragraph (a), and the prescriber has indicated "dispense as written" on the prescription in a manner consistent with section 151.21, subdivision 2.

(e) The basis for determining the amount of payment for drugs administered in an outpatient setting shall be the lower of the usual and customary cost submitted by the provider, 106 percent of the average sales price as determined by the United States Department of Health and Human Services pursuant to title XVIII, section 1847a of the federal Social Security Act, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner. If average sales price is unavailable, the amount of payment must be lower of the usual and customary cost submitted by the provider, the wholesale acquisition cost, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner. ~~Effective January 1, 2014,~~ The commissioner shall discount the payment rate for drugs obtained through the federal 340B Drug Pricing Program by ~~20~~ 28.6 percent. The payment for drugs administered in an outpatient setting shall be made to the administering facility

or practitioner. A retail or specialty pharmacy dispensing a drug for administration in an outpatient setting is not eligible for direct reimbursement.

(f) The commissioner may ~~negotiate lower reimbursement~~ establish maximum allowable cost rates for specialty pharmacy products ~~than the rates~~ that are lower than the ingredient cost formulas specified in paragraph (a). The commissioner may require individuals enrolled in the health care programs administered by the department to obtain specialty pharmacy products from providers with whom the commissioner has negotiated lower reimbursement rates. Specialty pharmacy products are defined as those used by a small number of recipients or recipients with complex and chronic diseases that require expensive and challenging drug regimens. Examples of these conditions include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms of cancer. Specialty pharmaceutical products include injectable and infusion therapies, biotechnology drugs, antihemophilic factor products, high-cost therapies, and therapies that require complex care. The commissioner shall consult with the Formulary Committee to develop a list of specialty pharmacy products subject to ~~this paragraph~~ maximum allowable cost reimbursement. In consulting with the Formulary Committee in developing this list, the commissioner shall take into consideration the population served by specialty pharmacy products, the current delivery system and standard of care in the state, and access to care issues. The commissioner shall have the discretion to adjust the ~~reimbursement rate~~ maximum allowable cost to prevent access to care issues.

(g) Home infusion therapy services provided by home infusion therapy pharmacies must be paid at rates according to subdivision 8d.

(h) The commissioner shall contract with a vendor to conduct a cost of dispensing survey for all pharmacies that are physically located in the state of Minnesota that dispense outpatient drugs under medical assistance. The commissioner shall ensure that the vendor has prior experience in conducting cost of dispensing surveys. Each pharmacy enrolled with the department to dispense outpatient prescription drugs to fee-for-service members must respond to the cost of dispensing survey. The commissioner may sanction a pharmacy under section 256B.064 for failure to respond. The commissioner shall require the vendor to measure a single statewide cost of dispensing for all responding pharmacies to measure the mean, mean weighted by total prescription volume, mean weighted by medical assistance prescription volume, median, median weighted by total prescription volume, and median weighted by total medical assistance prescription volume. The commissioner shall post a copy of the final cost of dispensing survey report on the department's website. The initial survey must be completed no later than January 1, 2021, and repeated every three years.

The commissioner shall provide a summary of the results of each cost of dispensing survey and provide recommendations for any changes to the dispensing fee to the chairs and ranking members of the legislative committees with jurisdiction over medical assistance pharmacy reimbursement.

(i) The commissioner shall increase the ingredient cost reimbursement calculated in paragraphs (a) and (f) by two percent for prescription and nonprescription drugs subject to the wholesale drug distributor tax under section 295.52.

EFFECTIVE DATE. This section is effective April 1, 2019, or upon federal approval, whichever is later. Paragraph (i) expires if federal approval is denied. The commissioner of human services shall inform the revisor of statutes when federal approval is obtained or denied.

Sec. 13. Minnesota Statutes 2018, section 256B.0625, subdivision 13f, is amended to read:

Subd. 13f. **Prior authorization.** (a) The Formulary Committee shall review and recommend drugs which require prior authorization. The Formulary Committee shall establish general criteria to be used for the prior authorization of brand-name drugs for which generically equivalent drugs are available, but the committee is not required to review each brand-name drug for which a generically equivalent drug is available.

(b) Prior authorization may be required by the commissioner before certain formulary drugs are eligible for payment. The Formulary Committee may recommend drugs for prior authorization directly to the commissioner. The commissioner may also request that the Formulary Committee review a drug for prior authorization. Before the commissioner may require prior authorization for a drug:

(1) the commissioner must provide information to the Formulary Committee on the impact that placing the drug on prior authorization may have on the quality of patient care and on program costs, information regarding whether the drug is subject to clinical abuse or misuse, and relevant data from the state Medicaid program if such data is available;

(2) the Formulary Committee must review the drug, taking into account medical and clinical data and the information provided by the commissioner; and

(3) the Formulary Committee must hold a public forum and receive public comment for an additional 15 days.

The commissioner must provide a 15-day notice period before implementing the prior authorization.

(c) Except as provided in subdivision 13j, prior authorization shall not be required or utilized for any atypical antipsychotic drug prescribed for the treatment of mental illness if:

(1) there is no generically equivalent drug available; and

(2) the drug was initially prescribed for the recipient prior to July 1, 2003; or

(3) the drug is part of the recipient's current course of treatment.

This paragraph applies to any multistate preferred drug list or supplemental drug rebate program established or administered by the commissioner. Prior authorization shall automatically be granted for 60 days for brand name drugs prescribed for treatment of mental illness within 60 days of when a generically equivalent drug becomes available, provided that the brand name drug was part of the recipient's course of treatment at the time the generically equivalent drug became available.

~~(d) Prior authorization shall not be required or utilized for any antihemophilic factor drug prescribed for the treatment of hemophilia and blood disorders where there is no generically equivalent drug available if the prior authorization is used in conjunction with any supplemental drug rebate program or multistate preferred drug list established or administered by the commissioner.~~

~~(e)~~ (d) The commissioner may require prior authorization for brand name drugs whenever a generically equivalent product is available, even if the prescriber specifically indicates "dispense as written-brand necessary" on the prescription as required by section 151.21, subdivision 2.

~~(f)~~ (e) Notwithstanding this subdivision, the commissioner may automatically require prior authorization, for a period not to exceed 180 days, for any drug that is approved by the United States Food and Drug Administration on or after July 1, 2005. The 180-day period begins no later than the first day that a drug is available for shipment to pharmacies within the state. The Formulary Committee shall recommend to the commissioner general criteria to be used for the prior authorization of the drugs, but the committee is not required to review each individual drug. In order to continue prior authorizations for a drug after the 180-day period has expired, the commissioner must follow the provisions of this subdivision.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 14. Minnesota Statutes 2018, section 256B.0625, subdivision 17, is amended to read:

Subd. 17. **Transportation costs.** (a) "Nonemergency medical transportation service" means motor vehicle transportation provided by a public or private person that serves Minnesota health care program beneficiaries who do not require emergency ambulance service, as defined in section 144E.001, subdivision 3, to obtain covered medical services.

(b) Medical assistance covers medical transportation costs incurred solely for obtaining emergency medical care or transportation costs incurred by eligible persons in obtaining emergency or nonemergency medical care when paid directly to an ambulance company, nonemergency medical transportation company, or other recognized providers of transportation services. Medical transportation must be provided by:

(1) nonemergency medical transportation providers who meet the requirements of this subdivision;

(2) ambulances, as defined in section 144E.001, subdivision 2;

(3) taxicabs that meet the requirements of this subdivision;

(4) public transit, as defined in section 174.22, subdivision 7; or

(5) not-for-hire vehicles, including volunteer drivers.

(c) Medical assistance covers nonemergency medical transportation provided by nonemergency medical transportation providers enrolled in the Minnesota health care programs. All nonemergency medical transportation providers must comply with the operating standards for special transportation service as defined in sections 174.29 to 174.30 and Minnesota Rules, chapter 8840, and ~~in consultation with the Minnesota Department of Transportation~~ all drivers must be individually enrolled with the commissioner and reported on the claim as the individual who provided the service. All nonemergency medical transportation providers shall bill for nonemergency medical transportation services in accordance with Minnesota health care programs criteria. Publicly operated transit systems, volunteers, and not-for-hire vehicles are exempt from the requirements outlined in this paragraph.

(d) An organization may be terminated, denied, or suspended from enrollment if:

(1) the provider has not initiated background studies on the individuals specified in section 174.30, subdivision 10, paragraph (a), clauses (1) to (3); or

(2) the provider has initiated background studies on the individuals specified in section 174.30, subdivision 10, paragraph (a), clauses (1) to (3), and:

(i) the commissioner has sent the provider a notice that the individual has been disqualified under section 245C.14; and

(ii) the individual has not received a disqualification set-aside specific to the special transportation services provider under sections 245C.22 and 245C.23.

(e) The administrative agency of nonemergency medical transportation must:

(1) adhere to the policies defined by the commissioner in consultation with the Nonemergency Medical Transportation Advisory Committee;

(2) pay nonemergency medical transportation providers for services provided to Minnesota health care programs beneficiaries to obtain covered medical services;

(3) provide data monthly to the commissioner on appeals, complaints, no-shows, canceled trips, and number of trips by mode; and

(4) by July 1, 2016, in accordance with subdivision 18e, utilize a web-based single administrative structure assessment tool that meets the technical requirements established by the commissioner, reconciles trip information with claims being submitted by providers, and ensures prompt payment for nonemergency medical transportation services.

(f) Until the commissioner implements the single administrative structure and delivery system under subdivision 18e, clients shall obtain their level-of-service certificate from the commissioner or an entity approved by the commissioner that does not dispatch rides for clients using modes of transportation under paragraph (i), clauses (4), (5), (6), and (7).

(g) The commissioner may use an order by the recipient's attending physician or a medical or mental health professional to certify that the recipient requires nonemergency medical transportation services. Nonemergency medical transportation providers shall perform driver-assisted services for eligible individuals, when appropriate. Driver-assisted service includes passenger pickup at and return to the individual's residence or place of business, assistance with admittance of the individual to the medical facility, and assistance in passenger securement or in securing of wheelchairs, child seats, or stretchers in the vehicle.

Nonemergency medical transportation providers must take clients to the health care provider using the most direct route, and must not exceed 30 miles for a trip to a primary care provider or 60 miles for a trip to a specialty care provider, unless the client receives authorization from the local agency.

Nonemergency medical transportation providers may not bill for separate base rates for the continuation of a trip beyond the original destination. Nonemergency medical transportation providers must maintain trip logs, which include pickup and drop-off times,

signed by the medical provider or client, whichever is deemed most appropriate, attesting to mileage traveled to obtain covered medical services. Clients requesting client mileage reimbursement must sign the trip log attesting mileage traveled to obtain covered medical services.

(h) The administrative agency shall use the level of service process established by the commissioner in consultation with the Nonemergency Medical Transportation Advisory Committee to determine the client's most appropriate mode of transportation. If public transit or a certified transportation provider is not available to provide the appropriate service mode for the client, the client may receive a onetime service upgrade.

(i) The covered modes of transportation are:

(1) client reimbursement, which includes client mileage reimbursement provided to clients who have their own transportation, or to family or an acquaintance who provides transportation to the client;

(2) volunteer transport, which includes transportation by volunteers using their own vehicle;

(3) unassisted transport, which includes transportation provided to a client by a taxicab or public transit. If a taxicab or public transit is not available, the client can receive transportation from another nonemergency medical transportation provider;

(4) assisted transport, which includes transport provided to clients who require assistance by a nonemergency medical transportation provider;

(5) lift-equipped/ramp transport, which includes transport provided to a client who is dependent on a device and requires a nonemergency medical transportation provider with a vehicle containing a lift or ramp;

(6) protected transport, which includes transport provided to a client who has received a prescreening that has deemed other forms of transportation inappropriate and who requires a provider: (i) with a protected vehicle that is not an ambulance or police car and has safety locks, a video recorder, and a transparent thermoplastic partition between the passenger and the vehicle driver; and (ii) who is certified as a protected transport provider; and

(7) stretcher transport, which includes transport for a client in a prone or supine position and requires a nonemergency medical transportation provider with a vehicle that can transport a client in a prone or supine position.

(j) The local agency shall be the single administrative agency and shall administer and reimburse for modes defined in paragraph (i) according to paragraphs (m) and (n) when the

commissioner has developed, made available, and funded the web-based single administrative structure, assessment tool, and level of need assessment under subdivision 18e. The local agency's financial obligation is limited to funds provided by the state or federal government.

(k) The commissioner shall:

(1) in consultation with the Nonemergency Medical Transportation Advisory Committee, verify that the mode and use of nonemergency medical transportation is appropriate;

(2) verify that the client is going to an approved medical appointment; and

(3) investigate all complaints and appeals.

(l) The administrative agency shall pay for the services provided in this subdivision and seek reimbursement from the commissioner, if appropriate. As vendors of medical care, local agencies are subject to the provisions in section 256B.041, the sanctions and monetary recovery actions in section 256B.064, and Minnesota Rules, parts 9505.2160 to 9505.2245.

(m) Payments for nonemergency medical transportation must be paid based on the client's assessed mode under paragraph (h), not the type of vehicle used to provide the service. The medical assistance reimbursement rates for nonemergency medical transportation services that are payable by or on behalf of the commissioner for nonemergency medical transportation services are:

(1) $0.22 per mile for client reimbursement;

(2) up to 100 percent of the Internal Revenue Service business deduction rate for volunteer transport;

(3) equivalent to the standard fare for unassisted transport when provided by public transit, and $11 for the base rate and $1.30 per mile when provided by a nonemergency medical transportation provider;

(4) $13 for the base rate and $1.30 per mile for assisted transport;

(5) $18 for the base rate and $1.55 per mile for lift-equipped/ramp transport;

(6) $75 for the base rate and $2.40 per mile for protected transport; and

(7) $60 for the base rate and $2.40 per mile for stretcher transport, and $9 per trip for an additional attendant if deemed medically necessary.

(n) The base rate for nonemergency medical transportation services in areas defined under RUCA to be super rural is equal to 111.3 percent of the respective base rate in

paragraph (m), clauses (1) to (7). The mileage rate for nonemergency medical transportation services in areas defined under RUCA to be rural or super rural areas is:

(1) for a trip equal to 17 miles or less, equal to 125 percent of the respective mileage rate in paragraph (m), clauses (1) to (7); and

(2) for a trip between 18 and 50 miles, equal to 112.5 percent of the respective mileage rate in paragraph (m), clauses (1) to (7).

(o) For purposes of reimbursement rates for nonemergency medical transportation services under paragraphs (m) and (n), the zip code of the recipient's place of residence shall determine whether the urban, rural, or super rural reimbursement rate applies.

(p) For purposes of this subdivision, "rural urban commuting area" or "RUCA" means a census-tract based classification system under which a geographical area is determined to be urban, rural, or super rural.

(q) The commissioner, when determining reimbursement rates for nonemergency medical transportation under paragraphs (m) and (n), shall exempt all modes of transportation listed under paragraph (i) from Minnesota Rules, part 9505.0445, item R, subitem (2).

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 15. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision to read:

Subd. 17d. **Transportation services oversight.** The commissioner shall contract with a vendor or dedicate staff to oversee providers of nonemergency medical transportation services pursuant to the commissioner's authority in section 256B.04 and Minnesota Rules, parts 9505.2160 to 9505.2245.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 16. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision to read:

Subd. 17e. **Transportation provider termination.** (a) A terminated nonemergency medical transportation provider, including all named individuals on the current enrollment disclosure form and known or discovered affiliates of the nonemergency medical transportation provider, is not eligible to enroll as a nonemergency medical transportation provider for five years following the termination.

(b) After the five-year period in paragraph (a), if a provider seeks to reenroll as a nonemergency medical transportation provider, the provider must be placed on a one-year probation period. During a provider's probation period the commissioner shall complete unannounced site visits and request documentation to review compliance with program requirements.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 17. Minnesota Statutes 2018, section 256B.0625, subdivision 57, is amended to read:

Subd. 57. **Payment for Part B Medicare crossover claims.** (a) Effective for services provided on or after January 1, 2012, medical assistance payment for an enrollee's cost-sharing associated with Medicare Part B is limited to an amount up to the medical assistance total allowed, when the medical assistance rate exceeds the amount paid by Medicare.

(b) Excluded from this limitation are payments for mental health services and payments for dialysis services provided to end-stage renal disease patients. The exclusion for mental health services does not apply to payments for physician services provided by psychiatrists and advanced practice nurses with a specialty in mental health.

(c) Excluded from this limitation are payments to federally qualified health centers, Indian Health Services, and rural health clinics.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 18. Minnesota Statutes 2018, section 256B.064, subdivision 1a, is amended to read:

Subd. 1a. **Grounds for sanctions against vendors.** (a) The commissioner may impose sanctions against a vendor of medical care for any of the following: (1) fraud, theft, or abuse in connection with the provision of medical care to recipients of public assistance; (2) a pattern of presentment of false or duplicate claims or claims for services not medically necessary; (3) a pattern of making false statements of material facts for the purpose of obtaining greater compensation than that to which the vendor is legally entitled; (4) suspension or termination as a Medicare vendor; (5) refusal to grant the state agency access during regular business hours to examine all records necessary to disclose the extent of services provided to program recipients and appropriateness of claims for payment; (6) failure to repay an overpayment or a fine finally established under this section; (7) failure to correct errors in the maintenance of health service or financial records for which a fine was imposed or after issuance of a warning by the commissioner; and (8) any reason for

which a vendor could be excluded from participation in the Medicare program under section 1128, 1128A, or 1866(b)(2) of the Social Security Act.

(b) The commissioner may impose sanctions against a pharmacy provider for failure to respond to a cost of dispensing survey under section 256B.0625, subdivision 13e, paragraph (h).

EFFECTIVE DATE. This section is effective April 1, 2019.

Sec. 19. Minnesota Statutes 2018, section 256B.0659, subdivision 21, is amended to read:

Subd. 21. **Requirements for provider enrollment of personal care assistance provider agencies.** (a) All personal care assistance provider agencies must provide, at the time of enrollment, reenrollment, and revalidation as a personal care assistance provider agency in a format determined by the commissioner, information and documentation that includes, but is not limited to, the following:

(1) the personal care assistance provider agency's current contact information including address, telephone number, and e-mail address;

(2) proof of surety bond coverage for each business location providing services. Upon new enrollment, or if the provider's Medicaid revenue in the previous calendar year is up to and including $300,000, the provider agency must purchase a surety bond of $50,000. If the Medicaid revenue in the previous year is over $300,000, the provider agency must purchase a surety bond of $100,000. The surety bond must be in a form approved by the commissioner, must be renewed annually, and must allow for recovery of costs and fees in pursuing a claim on the bond;

(3) proof of fidelity bond coverage in the amount of $20,000 for each business location providing service;

(4) proof of workers' compensation insurance coverage identifying the business location where personal care assistance services are provided;

(5) proof of liability insurance coverage identifying the business location where personal care assistance services are provided and naming the department as a certificate holder;

~~(6) a description of the personal care assistance provider agency's organization identifying the names of all owners, managing employees, staff, board of directors, and the affiliations of the directors, owners, or staff to other service providers;~~

~~(7)~~ (6) a copy of the personal care assistance provider agency's written policies and procedures including: hiring of employees; training requirements; service delivery; and

employee and consumer safety including process for notification and resolution of consumer grievances, identification and prevention of communicable diseases, and employee misconduct;

~~(8)~~ (7) copies of all other forms the personal care assistance provider agency uses in the course of daily business including, but not limited to:

(i) a copy of the personal care assistance provider agency's time sheet if the time sheet varies from the standard time sheet for personal care assistance services approved by the commissioner, and a letter requesting approval of the personal care assistance provider agency's nonstandard time sheet;

(ii) the personal care assistance provider agency's template for the personal care assistance care plan; and

(iii) the personal care assistance provider agency's template for the written agreement in subdivision 20 for recipients using the personal care assistance choice option, if applicable;

~~(9)~~ (8) a list of all training and classes that the personal care assistance provider agency requires of its staff providing personal care assistance services;

~~(10)~~ (9) documentation that the personal care assistance provider agency and staff have successfully completed all the training required by this section;

~~(11)~~ (10) documentation of the agency's marketing practices;

~~(12)~~ (11) disclosure of ownership, leasing, or management of all residential properties that is used or could be used for providing home care services;

~~(13)~~ (12) documentation that the agency will use the following percentages of revenue generated from the medical assistance rate paid for personal care assistance services for employee personal care assistant wages and benefits: 72.5 percent of revenue in the personal care assistance choice option and 72.5 percent of revenue from other personal care assistance providers. The revenue generated by the qualified professional and the reasonable costs associated with the qualified professional shall not be used in making this calculation; and

~~(14)~~ (13) effective May 15, 2010, documentation that the agency does not burden recipients' free exercise of their right to choose service providers by requiring personal care assistants to sign an agreement not to work with any particular personal care assistance recipient or for another personal care assistance provider agency after leaving the agency and that the agency is not taking action on any such agreements or requirements regardless of the date signed.

(b) Personal care assistance provider agencies shall provide the information specified in paragraph (a) to the commissioner at the time the personal care assistance provider agency enrolls as a vendor or upon request from the commissioner. The commissioner shall collect the information specified in paragraph (a) from all personal care assistance providers beginning July 1, 2009.

(c) All personal care assistance provider agencies shall require all employees in management and supervisory positions and owners of the agency who are active in the day-to-day management and operations of the agency to complete mandatory training as determined by the commissioner before submitting an application for enrollment of the agency as a provider. All personal care assistance provider agencies shall also require qualified professionals to complete the training required by subdivision 13 before submitting an application for enrollment of the agency as a provider. Employees in management and supervisory positions and owners who are active in the day-to-day operations of an agency who have completed the required training as an employee with a personal care assistance provider agency do not need to repeat the required training if they are hired by another agency, if they have completed the training within the past three years. By September 1, 2010, the required training must be available with meaningful access according to title VI of the Civil Rights Act and federal regulations adopted under that law or any guidance from the United States Health and Human Services Department. The required training must be available online or by electronic remote connection. The required training must provide for competency testing. Personal care assistance provider agency billing staff shall complete training about personal care assistance program financial management. This training is effective July 1, 2009. Any personal care assistance provider agency enrolled before that date shall, if it has not already, complete the provider training within 18 months of July 1, 2009. Any new owners or employees in management and supervisory positions involved in the day-to-day operations are required to complete mandatory training as a requisite of working for the agency. Personal care assistance provider agencies certified for participation in Medicare as home health agencies are exempt from the training required in this subdivision. When available, Medicare-certified home health agency owners, supervisors, or managers must successfully complete the competency test.

(d) All surety bonds, fidelity bonds, workers compensation insurance, and liability insurance required by this subdivision must be maintained continuously. After initial enrollment, a provider must submit proof of bonds and required coverages at any time at the request of the commissioner. Services provided while there are lapses in coverage are not eligible for payment. Lapses in coverage may result in sanctions, including termination.

The commissioner shall send instructions and a due date to submit the requested information to the personal care assistance provider agency.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 20. **[256B.688] PROVIDER TAX RATE INCREASE.**

(a) The commissioner shall increase the total payments to managed care plans under section 256B.69 by an amount equal to the cost increases to the managed care plans from the elimination of:

(1) the exemption from the taxes imposed under section 297I.05, subdivision 5, for premiums paid by the state for medical assistance and the MinnesotaCare program; and

(2) the exemption of gross revenues subject to the taxes imposed under sections 295.50 to 295.57, for payments paid by the state for services provided under medical assistance and the MinnesotaCare program. Any increase based on clause (2) must be reflected in provider rates paid by the managed care plan unless the managed care plan is a staff model health plan company.

(b) The commissioner shall increase by two percent the fee-for-service payments under medical assistance and the MinnesotaCare program for services subject to the hospital, surgical center, or health care provider taxes under sections 295.50 to 295.57.

Sec. 21. Minnesota Statutes 2018, section 256B.766, is amended to read:

256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.

Subdivision 1. **Generally.** (a) Effective for services provided on or after July 1, 2009, total payments for basic care services, shall be reduced by three percent, except that for the period July 1, 2009, through June 30, 2011, total payments shall be reduced by 4.5 percent for the medical assistance and general assistance medical care programs, prior to third-party liability and spenddown calculation. Effective July 1, 2010, the commissioner shall classify physical therapy services, occupational therapy services, and speech-language pathology and related services as basic care services. The reduction in this paragraph shall apply to physical therapy services, occupational therapy services, and speech-language pathology and related services provided on or after July 1, 2010.

(b) Payments made to managed care plans and county-based purchasing plans shall be reduced for services provided on or after October 1, 2009, to reflect the reduction effective July 1, 2009, and payments made to the plans shall be reduced effective October 1, 2010, to reflect the reduction effective July 1, 2010.

(c) Effective for services provided on or after September 1, 2011, through June 30, 2013, total payments for outpatient hospital facility fees shall be reduced by five percent from the rates in effect on August 31, 2011.

(d) Effective for services provided on or after September 1, 2011, through June 30, 2013, total payments for ambulatory surgery centers facility fees, medical supplies and durable medical equipment not subject to a volume purchase contract, prosthetics and orthotics, renal dialysis services, laboratory services, public health nursing services, physical therapy services, occupational therapy services, speech therapy services, eyeglasses not subject to a volume purchase contract, hearing aids not subject to a volume purchase contract, and anesthesia services shall be reduced by three percent from the rates in effect on August 31, 2011.

(e) Effective for services provided on or after September 1, 2014, payments for ambulatory surgery centers facility fees, hospice services, renal dialysis services, laboratory services, public health nursing services, eyeglasses not subject to a volume purchase contract, and hearing aids not subject to a volume purchase contract shall be increased by three percent and payments for outpatient hospital facility fees shall be increased by three percent. Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

(f) Payments for medical supplies and durable medical equipment not subject to a volume purchase contract, and prosthetics and orthotics, provided on or after July 1, 2014, through June 30, 2015, shall be decreased by .33 percent. Payments for medical supplies and durable medical equipment not subject to a volume purchase contract, and prosthetics and orthotics, provided on or after July 1, 2015, shall be increased by three percent from the rates as determined under paragraphs (i) and (j).

(g) Effective for services provided on or after July 1, 2015, payments for outpatient hospital facility fees, medical supplies and durable medical equipment not subject to a volume purchase contract, prosthetics, and orthotics to a hospital meeting the criteria specified in section 62Q.19, subdivision 1, paragraph (a), clause (4), shall be increased by 90 percent from the rates in effect on June 30, 2015. Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

(h) This ~~section~~ subdivision does not apply to physician and professional services, inpatient hospital services, family planning services, mental health services, dental services, prescription drugs, medical transportation, federally qualified health centers, rural health centers, Indian health services, and Medicare cost-sharing.

~~(i) Effective for services provided on or after July 1, 2015, the following categories of medical supplies and durable medical equipment shall be individually priced items: enteral nutrition and supplies, customized and other specialized tracheostomy tubes and supplies, electric patient lifts, and durable medical equipment repair and service. This paragraph does not apply to medical supplies and durable medical equipment subject to a volume purchase contract, products subject to the preferred diabetic testing supply program, and items provided to dually eligible recipients when Medicare is the primary payer for the item. The commissioner shall not apply any medical assistance rate reductions to durable medical equipment as a result of Medicare competitive bidding.~~

~~(j) Effective for services provided on or after July 1, 2015, medical assistance payment rates for durable medical equipment, prosthetics, orthotics, or supplies shall be increased as follows:~~

~~(1) payment rates for durable medical equipment, prosthetics, orthotics, or supplies that were subject to the Medicare competitive bid that took effect in January of 2009 shall be increased by 9.5 percent; and~~

~~(2) payment rates for durable medical equipment, prosthetics, orthotics, or supplies on the medical assistance fee schedule, whether or not subject to the Medicare competitive bid that took effect in January of 2009, shall be increased by 2.94 percent, with this increase being applied after calculation of any increased payment rate under clause (1).~~

~~This paragraph does not apply to medical supplies and durable medical equipment subject to a volume purchase contract, products subject to the preferred diabetic testing supply program, items provided to dually eligible recipients when Medicare is the primary payer for the item, and individually priced items identified in paragraph (i). Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect the rate increases in this paragraph.~~

~~(k)~~ (i) Effective for nonpressure support ventilators provided on or after January 1, 2016, the rate shall be the lower of the submitted charge or the Medicare fee schedule rate. Effective for pressure support ventilators provided on or after January 1, 2016, the rate shall be the lower of the submitted charge or 47 percent above the Medicare fee schedule rate. For payments made in accordance with this paragraph, if, and to the extent that, the commissioner identifies that the state has received federal financial participation for ventilators in excess of the amount allowed effective January 1, 2018, under United States Code, title 42, section 1396b(i)(27), the state shall repay the excess amount to the Centers for Medicare and Medicaid Services with state funds and maintain the full payment rate under this paragraph.

Subd. 2. **Durable medical equipment.** (a) Notwithstanding Minnesota Rules, part 9505.0445, item S, this subdivision governs medical assistance rates for medical supplies and equipment described under this subdivision. Payment rates for all durable medical equipment, prosthetics, orthotics, or supplies that are not subject to a volume purchase contract, preferred product program, or competitively bid contract, and not reimbursed under paragraph (b), shall be the lesser of the provider's submitted charges or the Medicare non-rural fee schedule amount applicable on the date of service, with no increase or decrease described in subdivision 1.

(b) Payment rates for durable medical equipment, prosthetics, orthotics, or supplies that are not subject to a volume purchase contract, preferred product program, or competitively bid contract for which Medicare has not established a payment amount shall be the lesser of the provider's submitted charges, or the alternative payment methodology rate described in paragraphs (c) to (h), with no increase or decrease described in subdivision 1.

(c) The alternate payment methodology rate is calculated from either:

(1) at least 100 paid claim lines, as priced under paragraph (f), provided by at least ten different providers within one calendar month for services that are provided at least 100 times in a calendar month; or

(2) at least 20 paid claim lines, as priced under paragraph (f), submitted by at least five different providers within two consecutive quarters for services that are not provided 100 times in a calendar month.

(d) The alternate payment methodology rate is the mean of the payment per unit of the claim lines, with the top and bottom ten percent of claim lines, by amount of payment per unit, excluded from the calculation of the mean.

(e) The alternate payment methodology rate is added to the commissioner's fee schedule on the first day of a calendar month, or the first day of a calendar quarter if claims from more than one month are used to determine the rate. The alternate payment methodology rate is subject to Medicare's inflation or deflation factor on January 1 of each year unless the rate was calculated and posted to the fee schedule after July 1 of the previous year.

(f) Not more than once every three years, the commissioner must evaluate the alternate payment methodology rate for reasonableness by reviewing invoices from at least 20 paid claim lines and five different providers for services provided during one calendar month, or one quarter if necessary to obtain the required sample. If the evaluation demonstrates that the alternate payment methodology rate is more than five percent higher or lower than the provider's actual acquisition cost plus 20 percent, the commissioner shall recalculate

and update the alternate payment methodology fee schedule according to paragraphs (c) to (e). If the evaluation demonstrates that the alternate payment methodology fee schedule rate is not five percent higher or lower than the provider's actual acquisition cost plus 20 percent, or a sufficient sample of claims according to paragraph (a) cannot be collected due to low utilization, the commissioner shall maintain the previously calculated alternate payment methodology fee schedule.

(g) Until sufficient data is available to calculate the alternative payment methodology rate, the payment is based on the provider's actual acquisition cost plus 20 percent as documented on an invoice submitted by the provider. The payment may be based on a quote the provider received from a vendor showing the provider's actual acquisition cost only if the durable medical equipment, prosthetic, orthotic, or supply requires authorization and the rate is required to complete the authorization.

(h) When procuring goods or services under competitive bidding authority in section 256B.04, the commissioner may establish a payment rate for the procured services, or establish a fee schedule, based on the following:

(1) the contracted rate established through a competitive procurement process;

(2) actual acquisition cost plus 20 percent consistent with paragraph (f); or

(3) a rate or rate methodology established by an administrative rule.

Sec. 22. Minnesota Statutes 2018, section 256B.767, is amended to read:

256B.767 MEDICARE PAYMENT LIMIT.

(a) Effective for services rendered on or after July 1, 2010, fee-for-service payment rates for physician and professional services under section 256B.76, subdivision 1, and basic care services subject to the rate reduction specified in section 256B.766, shall not exceed the Medicare payment rate for the applicable service, as adjusted for any changes in Medicare payment rates after July 1, 2010. The commissioner shall implement this section after any other rate adjustment that is effective July 1, 2010, and shall reduce rates under this section by first reducing or eliminating provider rate add-ons.

(b) This section does not apply to services provided by advanced practice certified nurse midwives licensed under chapter 148 or traditional midwives licensed under chapter 147D. Notwithstanding this exemption, medical assistance fee-for-service payment rates for advanced practice certified nurse midwives and licensed traditional midwives shall equal and shall not exceed the medical assistance payment rate to physicians for the applicable service.

(c) This section does not apply to mental health services or physician services billed by a psychiatrist or an advanced practice registered nurse with a specialty in mental health.

(d) ~~Effective July 1, 2015,~~ This section shall not apply to durable medical equipment, prosthetics, orthotics, or supplies specified in section 256B.766, paragraph (k).

(e) This section does not apply to physical therapy, occupational therapy, speech pathology and related services, and basic care services provided by a hospital meeting the criteria specified in section 62Q.19, subdivision 1, paragraph (a), clause (4).

Sec. 23. Laws 2003, First Special Session chapter 14, article 13C, section 2, subdivision 6, as amended by Laws 2004, chapter 272, article 2, section 4; Laws 2005, First Special Session chapter 4, article 5, section 18; and Laws 2005, First Special Session chapter 4, article 9, section 11, is amended to read:

Subd. 6. **Basic Health Care Grants**

	Summary by Fund	
General	1,290,454,000	1,475,996,000
Health Care Access	254,121,000	282,689,000

UPDATING FEDERAL POVERTY GUIDELINES. Annual updates to the federal poverty guidelines are effective each July 1, following publication by the United States Department of Health and Human Services for health care programs under Minnesota Statutes, chapters 256, 256B, 256D, and 256L.

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) MinnesotaCare Grants

Health Care Access	253,371,000	281,939,000

MINNESOTACARE FEDERAL RECEIPTS. Receipts received as a result of federal participation pertaining to administrative costs of the Minnesota health care reform waiver shall be deposited as nondedicated revenue in the health care access

fund. Receipts received as a result of federal participation pertaining to grants shall be deposited in the federal fund and shall offset health care access funds for payments to providers.

MINNESOTACARE FUNDING. The commissioner may expend money appropriated from the health care access fund for MinnesotaCare in either fiscal year of the biennium.

(b) MA Basic Health Care Grants - Families and Children

General	427,769,000	489,545,000

SERVICES TO PREGNANT WOMEN. The commissioner shall use available federal money for the State-Children's Health Insurance Program for medical assistance services provided to pregnant women who are not otherwise eligible for federal financial participation beginning in fiscal year 2003. This federal money shall be deposited in the federal fund and shall offset general funds for payments to providers. Notwithstanding section 14, this paragraph shall not expire.

MANAGED CARE RATE INCREASE. ~~(a) Effective January 1, 2004, the commissioner of human services shall increase the total payments to managed care plans under Minnesota Statutes, section 256B.69, by an amount equal to the cost increases to the managed care plans from by the elimination of: (1) the exemption from the taxes imposed under Minnesota Statutes, section 297I.05, subdivision 5, for premiums paid by the state~~

~~for medical assistance, general assistance medical care, and the MinnesotaCare program; and (2) the exemption of gross revenues subject to the taxes imposed under Minnesota Statutes, sections 295.50 to 295.57, for payments paid by the state for services provided under medical assistance, general assistance medical care, and the MinnesotaCare program. Any increase based on clause (2) must be reflected in provider rates paid by the managed care plan unless the managed care plan is a staff model health plan company.~~

~~(b) The commissioner of human services shall increase by the applicable tax rate in effect under Minnesota Statutes, section 295.52, the fee-for-service payments under medical assistance, general assistance medical care, and the MinnesotaCare program for services subject to the hospital, surgical center, or health care provider taxes under Minnesota Statutes, sections 295.50 to 295.57, effective for services rendered on or after January 1, 2004.~~

(c) The commissioner of finance shall transfer from the health care access fund to the general fund the following amounts in the fiscal years indicated: 2004, $16,587,000; 2005, $46,322,000; 2006, $49,413,000; and 2007, $58,695,000.

(d) Notwithstanding section 14, these provisions shall not expire.

(c) MA Basic Health Care Grants - Elderly and Disabled

General	610,518,000	743,858,000

DELAY MEDICAL ASSISTANCE FEE-FOR-SERVICE - ACUTE CARE. The following payments in fiscal year 2005 from the Medicaid Management Information System that would otherwise have been made to providers for medical assistance and general assistance medical care services shall be delayed and included in the first payment in fiscal year 2006:

(1) for hospitals, the last two payments; and

(2) for nonhospital providers, the last payment.

This payment delay shall not include payments to skilled nursing facilities, intermediate care facilities for mental retardation, prepaid health plans, home health agencies, personal care nursing providers, and providers of only waiver services. The provisions of Minnesota Statutes, section 16A.124, shall not apply to these delayed payments. Notwithstanding section 14, this provision shall not expire.

DEAF AND HARD-OF-HEARING SERVICES. If, after making reasonable efforts, the service provider for mental health services to persons who are deaf or hearing impaired is not able to earn $227,000 through participation in medical assistance intensive rehabilitation services in fiscal year 2005, the commissioner shall transfer $227,000 minus medical assistance earnings achieved by the grantee to deaf and hard-of-hearing grants to enable the provider to continue providing services to eligible persons.

(d) General Assistance Medical Care Grants

General	239,861,000	229,960,000

(e) Health Care Grants - Other Assistance

General	3,067,000	3,407,000
Health Care Access	750,000	750,000

MINNESOTA PRESCRIPTION DRUG DEDICATED FUND. Of the general fund appropriation, $284,000 in fiscal year 2005 is appropriated to the commissioner for the prescription drug dedicated fund established under the prescription drug discount program.

DENTAL ACCESS GRANTS CARRYOVER AUTHORITY. Any unspent portion of the appropriation from the health care access fund in fiscal years 2002 and 2003 for dental access grants under Minnesota Statutes, section 256B.53, shall not cancel but shall be allowed to carry forward to be spent in the biennium beginning July 1, 2003, for these purposes.

STOP-LOSS FUND ACCOUNT. The appropriation to the purchasing alliance stop-loss fund account established under Minnesota Statutes, section 256.956, subdivision 2, for fiscal years 2004 and 2005 shall only be available for claim reimbursements for qualifying enrollees who are members of purchasing alliances that meet the requirements described under Minnesota Statutes, section 256.956, subdivision 1, paragraph (f), clauses (1), (2), and (3).

(f) Prescription Drug Program

General	9,239,000	9,226,000

PRESCRIPTION DRUG ASSISTANCE PROGRAM. Of the general fund

appropriation, $702,000 in fiscal year 2004 and $887,000 in fiscal year 2005 are for the commissioner to establish and administer the prescription drug assistance program through the Minnesota board on aging.

REBATE REVENUE RECAPTURE. Any funds received by the state from a drug manufacturer due to errors in the pharmaceutical pricing used by the manufacturer in determining the prescription drug rebate are appropriated to the commissioner to augment funding of the prescription drug program established in Minnesota Statutes, section 256.955.

Sec. 24. **REPEALER.**

Minnesota Statutes 2018, section 256B.0659, subdivision 22, is repealed.

ARTICLE 9
ONECARE BUY-IN

Section 1. Minnesota Statutes 2018, section 62J.497, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** (a) For the purposes of this section, the following terms have the meanings given.

(b) "Backward compatible" means that the newer version of a data transmission standard would retain, at a minimum, the full functionality of the versions previously adopted, and would permit the successful completion of the applicable transactions with entities that continue to use the older versions.

(c) "Dispense" or "dispensing" has the meaning given in section 151.01, subdivision 30. Dispensing does not include the direct administering of a controlled substance to a patient by a licensed health care professional.

(d) "Dispenser" means a person authorized by law to dispense a controlled substance, pursuant to a valid prescription.

(e) "Electronic media" has the meaning given under Code of Federal Regulations, title 45, part 160.103.

(f) "E-prescribing" means the transmission using electronic media of prescription or prescription-related information between a prescriber, dispenser, pharmacy benefit manager, or group purchaser, either directly or through an intermediary, including an e-prescribing network. E-prescribing includes, but is not limited to, two-way transmissions between the point of care and the dispenser and two-way transmissions related to eligibility, formulary, and medication history information.

(g) "Electronic prescription drug program" means a program that provides for e-prescribing.

(h) "Group purchaser" has the meaning given in section 62J.03, subdivision 6~~.~~, excluding state and federal health care programs under chapters 256B, 256L, and 256T.

(i) "HL7 messages" means a standard approved by the standards development organization known as Health Level Seven.

(j) "National Provider Identifier" or "NPI" means the identifier described under Code of Federal Regulations, title 45, part 162.406.

(k) "NCPDP" means the National Council for Prescription Drug Programs, Inc.

(l) "NCPDP Formulary and Benefits Standard" means the National Council for Prescription Drug Programs Formulary and Benefits Standard, Implementation Guide, Version 1, Release 0, October 2005.

(m) "NCPDP SCRIPT Standard" means the National Council for Prescription Drug Programs Prescriber/Pharmacist Interface SCRIPT Standard, Implementation Guide Version 8, Release 1 (Version 8.1), October 2005, or the most recent standard adopted by the Centers for Medicare and Medicaid Services for e-prescribing under Medicare Part D as required by section 1860D-4(e)(4)(D) of the Social Security Act, and regulations adopted under it. The standards shall be implemented according to the Centers for Medicare and Medicaid Services schedule for compliance. Subsequently released versions of the NCPDP SCRIPT Standard may be used, provided that the new version of the standard is backward compatible to the current version adopted by the Centers for Medicare and Medicaid Services.

(n) "Pharmacy" has the meaning given in section 151.01, subdivision 2.

(o) "Prescriber" means a licensed health care practitioner, other than a veterinarian, as defined in section 151.01, subdivision 23.

(p) "Prescription-related information" means information regarding eligibility for drug benefits, medication history, or related health or drug information.

(q) "Provider" or "health care provider" has the meaning given in section 62J.03, subdivision 8.

EFFECTIVE DATE. This section is effective January 1, 2022.

Sec. 2. **[256B.0371] ADMINISTRATION OF DENTAL SERVICES.**

Subdivision 1. **Contract for dental administration services.** (a) Effective January 1, 2022, the commissioner shall contract with up to two dental administrators to administer dental services for all recipients of medical assistance and MinnesotaCare.

(b) The dental administrator must provide administrative services including but not limited to:

(1) provider recruitment, contracting, and assistance;

(2) recipient outreach and assistance;

(3) utilization management and review for medical necessity of dental services;

(4) dental claims processing;

(5) coordination with other services;

(6) management of fraud and abuse;

(7) monitoring of access to dental services;

(8) performance measurement;

(9) quality improvement and evaluation requirements; and

(10) management of third-party liability requirements.

(c) Payments to contracted dental providers must be at the rates established under section 256B.76.

EFFECTIVE DATE. This section is effective January 1, 2022.

Sec. 3. Minnesota Statutes 2018, section 256B.0644, is amended to read:

256B.0644 REIMBURSEMENT UNDER OTHER STATE HEALTH CARE PROGRAMS.

(a) A vendor of medical care, as defined in section 256B.02, subdivision 7, and a health maintenance organization, as defined in chapter 62D, must participate as a provider or contractor in the medical assistance program and MinnesotaCare as a condition of participating as a provider in health insurance plans and programs or contractor for state

employees established under section 43A.18, the public employees insurance program under section 43A.316, for health insurance plans offered to local statutory or home rule charter city, county, and school district employees, the workers' compensation system under section 176.135, and insurance plans provided through the Minnesota Comprehensive Health Association under sections 62E.01 to 62E.19. The limitations on insurance plans offered to local government employees shall not be applicable in geographic areas where provider participation is limited by managed care contracts with the Department of Human Services. This section does not apply to dental service providers providing dental services outside the seven-county metropolitan area.

(b) For providers other than health maintenance organizations, participation in the medical assistance program means that:

(1) the provider accepts new medical assistance and MinnesotaCare patients;

(2) for providers other than dental service providers, at least 20 percent of the provider's patients are covered by medical assistance and MinnesotaCare as their primary source of coverage; or

(3) for dental service providers providing dental services in the seven-county metropolitan area, at least ten percent of the provider's patients are covered by medical assistance and MinnesotaCare as their primary source of coverage, or the provider accepts new medical assistance and MinnesotaCare patients who are children with special health care needs. For purposes of this section, "children with special health care needs" means children up to age 18 who: (i) require health and related services beyond that required by children generally; and (ii) have or are at risk for a chronic physical, developmental, behavioral, or emotional condition, including: bleeding and coagulation disorders; immunodeficiency disorders; cancer; endocrinopathy; developmental disabilities; epilepsy, cerebral palsy, and other neurological diseases; visual impairment or deafness; Down syndrome and other genetic disorders; autism; fetal alcohol syndrome; and other conditions designated by the commissioner after consultation with representatives of pediatric dental providers and consumers.

(c) Patients seen on a volunteer basis by the provider at a location other than the provider's usual place of practice may be considered in meeting the participation requirement in this section. The commissioner shall establish participation requirements for health maintenance organizations. The commissioner shall provide lists of participating medical assistance providers on a quarterly basis to the commissioner of management and budget, the commissioner of labor and industry, and the commissioner of commerce. Each of the

commissioners shall develop and implement procedures to exclude as participating providers in the program or programs under their jurisdiction those providers who do not participate in the medical assistance program. The commissioner of management and budget shall implement this section through contracts with participating health and dental carriers.

(d) A volunteer dentist who has signed a volunteer agreement under section 256B.0625, subdivision 9a, shall not be considered to be participating in medical assistance or MinnesotaCare for the purpose of this section.

(e) A vendor of medical care, as defined in section 256B.02, subdivision 7, that dispenses outpatient prescription drugs in accordance with chapter 151 must participate as a provider or contractor in the MinnesotaCare program as a condition of participating as a provider in the medical assistance program.

EFFECTIVE DATE. This section is effective January 1, 2022.

Sec. 4. Minnesota Statutes 2018, section 256B.69, subdivision 6d, is amended to read:

Subd. 6d. **Prescription drugs.** The commissioner may exclude or modify coverage for prescription drugs from the prepaid managed care contracts entered into under this section ~~in order to increase savings to the state by collecting additional prescription drug rebates. The contracts must maintain incentives for the managed care plan to manage drug costs and utilization and may require that the managed care plans maintain an open drug formulary. In order to manage drug costs and utilization, the contracts may authorize the managed care plans to use preferred drug lists and prior authorization. This subdivision is contingent on federal approval of the managed care contract changes and the collection of additional prescription drug rebates~~.

EFFECTIVE DATE. This section is effective January 1, 2022.

Sec. 5. Minnesota Statutes 2018, section 256B.76, subdivision 2, is amended to read:

Subd. 2. **Dental reimbursement.** (a) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for dental services as follows:

(1) dental services shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992; and

(2) dental rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases.

(b) Beginning October 1, 1999, the payment for tooth sealants and fluoride treatments shall be the lower of (1) submitted charge, or (2) 80 percent of median 1997 charges.

(c) Effective for services rendered on or after January 1, 2000, payment rates for dental services shall be increased by three percent over the rates in effect on December 31, 1999.

(d) Effective for services provided on or after January 1, 2002, payment for diagnostic examinations and dental x-rays provided to children under age 21 shall be the lower of (1) the submitted charge, or (2) 85 percent of median 1999 charges.

(e) The increases listed in paragraphs (b) and (c) shall be implemented January 1, 2000, for managed care.

(f) Effective for dental services rendered on or after October 1, 2010, by a state-operated dental clinic, payment shall be paid on a reasonable cost basis that is based on the Medicare principles of reimbursement. This payment shall be effective for services rendered on or after January 1, 2011, to recipients enrolled in managed care plans or county-based purchasing plans.

(g) Beginning in fiscal year 2011, if the payments to state-operated dental clinics in paragraph (f), including state and federal shares, are less than $1,850,000 per fiscal year, a supplemental state payment equal to the difference between the total payments in paragraph (f) and $1,850,000 shall be paid from the general fund to state-operated services for the operation of the dental clinics.

(h) If the cost-based payment system for state-operated dental clinics described in paragraph (f) does not receive federal approval, then state-operated dental clinics shall be designated as critical access dental providers under subdivision 4, paragraph (b), and shall receive the critical access dental reimbursement rate as described under subdivision 4, paragraph (a).

(i) Effective for services rendered on or after September 1, 2011, through June 30, 2013, payment rates for dental services shall be reduced by three percent. This reduction does not apply to state-operated dental clinics in paragraph (f).

(j) Effective for services rendered on or after January 1, 2014, payment rates for dental services shall be increased by five percent from the rates in effect on December 31, 2013. This increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, and Indian health services. Effective January 1, 2014, payments made to managed care plans and county-based purchasing plans under

sections 256B.69, 256B.692, and 256L.12 shall reflect the payment increase described in this paragraph.

(k) Effective for services rendered on or after July 1, 2015, through December 31, 2016, the commissioner shall increase payment rates for services furnished by dental providers located outside of the seven-county metropolitan area by the maximum percentage possible above the rates in effect on June 30, 2015, while remaining within the limits of funding appropriated for this purpose. This increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, and Indian health services. Effective January 1, 2016, through December 31, 2016, payments to managed care plans and county-based purchasing plans under sections 256B.69 and 256B.692 shall reflect the payment increase described in this paragraph. The commissioner shall require managed care and county-based purchasing plans to pass on the full amount of the increase, in the form of higher payment rates to dental providers located outside of the seven-county metropolitan area.

(l) Effective for services provided on or after January 1, 2017, through December 31, 2021, the commissioner shall increase payment rates by 9.65 percent for dental services provided outside of the seven-county metropolitan area. This increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, or Indian health services. Effective January 1, 2017, payments to managed care plans and county-based purchasing plans under sections 256B.69 and 256B.692 shall reflect the payment increase described in this paragraph.

(m) Effective for services provided on or after July 1, 2017, through December 31, 2021, the commissioner shall increase payment rates by 23.8 percent for dental services provided to enrollees under the age of 21. This rate increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, or Indian health centers. This rate increase does not apply to managed care plans and county-based purchasing plans.

(n) Effective for dental services provided on or after January 1, 2022, the commissioner shall increase payment rates by 54 percent. This rate increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, or Indian health centers.

Sec. 6. Minnesota Statutes 2018, section 256B.76, subdivision 4, is amended to read:

Subd. 4. **Critical access dental providers.** (a) The commissioner shall increase reimbursements to dentists and dental clinics deemed by the commissioner to be critical

access dental providers. For dental services rendered on or after July 1, 2016, through December 31, 2021, the commissioner shall increase reimbursement by 37.5 percent above the reimbursement rate that would otherwise be paid to the critical access dental provider, except as specified under paragraph (b). The commissioner shall pay the managed care plans and county-based purchasing plans in amounts sufficient to reflect increased reimbursements to critical access dental providers as approved by the commissioner.

(b) For dental services rendered on or after July 1, 2016, by a dental clinic or dental group that meets the critical access dental provider designation under paragraph (d), clause (4), and is owned and operated by a health maintenance organization licensed under chapter 62D, the commissioner shall increase reimbursement by 35 percent above the reimbursement rate that would otherwise be paid to the critical access provider.

(c) Critical access dental payments made under paragraph (a) or (b) for dental services provided by a critical access dental provider to an enrollee of a managed care plan or county-based purchasing plan must not reflect any capitated payments or cost-based payments from the managed care plan or county-based purchasing plan. The managed care plan or county-based purchasing plan must base the additional critical access dental payment on the amount that would have been paid for that service had the dental provider been paid according to the managed care plan or county-based purchasing plan's fee schedule that applies to dental providers that are not paid under a capitated payment or cost-based payment.

(d) The commissioner shall designate the following dentists and dental clinics as critical access dental providers:

(1) nonprofit community clinics that:

(i) have nonprofit status in accordance with chapter 317A;

(ii) have tax exempt status in accordance with the Internal Revenue Code, section 501(c)(3);

(iii) are established to provide oral health services to patients who are low income, uninsured, have special needs, and are underserved;

(iv) have professional staff familiar with the cultural background of the clinic's patients;

(v) charge for services on a sliding fee scale designed to provide assistance to low-income patients based on current poverty income guidelines and family size;

(vi) do not restrict access or services because of a patient's financial limitations or public assistance status; and

(vii) have free care available as needed;

(2) federally qualified health centers, rural health clinics, and public health clinics;

(3) hospital-based dental clinics owned and operated by a city, county, or former state hospital as defined in section 62Q.19, subdivision 1, paragraph (a), clause (4);

(4) a dental clinic or dental group owned and operated by a nonprofit corporation in accordance with chapter 317A with more than 10,000 patient encounters per year with patients who are uninsured or covered by medical assistance or MinnesotaCare;

(5) a dental clinic owned and operated by the University of Minnesota or the Minnesota State Colleges and Universities system; and

(6) private practicing dentists if:

(i) the dentist's office is located within the seven-county metropolitan area and more than 50 percent of the dentist's patient encounters per year are with patients who are uninsured or covered by medical assistance or MinnesotaCare; or

(ii) the dentist's office is located outside the seven-county metropolitan area and more than 25 percent of the dentist's patient encounters per year are with patients who are uninsured or covered by medical assistance or MinnesotaCare.

Sec. 7. Minnesota Statutes 2018, section 256L.03, is amended by adding a subdivision to read:

Subd. 7. **Outpatient prescription drugs.** Outpatient prescription drugs are covered according to section 256L.30. This subdivision applies to all individuals enrolled in the MinnesotaCare program.

EFFECTIVE DATE. This section is effective January 1, 2022.

Sec. 8. Minnesota Statutes 2018, section 256L.11, subdivision 7, is amended to read:

Subd. 7. **Critical access dental providers.** Effective for dental services provided to MinnesotaCare enrollees on or after July 1, 2017, through December 31, 2021, the commissioner shall increase payment rates to dentists and dental clinics deemed by the commissioner to be critical access providers under section 256B.76, subdivision 4, by 20 percent above the payment rate that would otherwise be paid to the provider. The commissioner shall pay the prepaid health plans under contract with the commissioner amounts sufficient to reflect this rate increase. The prepaid health plan must pass this rate

increase to providers who have been identified by the commissioner as critical access dental providers under section 256B.76, subdivision 4.

Sec. 9. **[256L.30] OUTPATIENT PRESCRIPTION DRUGS.**

Subdivision 1. **Establishment of program.** The commissioner shall administer and oversee the outpatient prescription drug program for MinnesotaCare. The commissioner shall not include the outpatient pharmacy benefit in a contract with a public or private entity.

Subd. 2. **Covered outpatient prescription drugs.** (a) In consultation with the Drug Formulary Committee under section 256B.0625, subdivision 13d, the commissioner shall establish an outpatient prescription drug formulary for MinnesotaCare that satisfies the requirements for an essential health benefit under Code of Federal Regulations, title 45, section 156.122. The commissioner may modify the formulary after consulting with the Drug Formulary Committee and providing public notice and the opportunity for public comment. The commissioner is exempt from the rulemaking requirements of chapter 14 to establish the drug formulary, and section 14.386 does not apply. The commissioner shall make the drug formulary available to the public on the agency website.

(b) The MinnesotaCare formulary must contain at least one drug in every United States Pharmacopeia category and class or the same number of prescription drugs in each category and class as the essential health benefit benchmark plan, whichever is greater.

(c) The commissioner may negotiate drug rebates or discounts directly with a drug manufacturer to place a drug on the formulary. The commissioner may also negotiate drug rebates, or discounts, with a drug manufacturer through a contract with a vendor.

(d) Prior authorization may be required by the commissioner before certain formulary drugs are eligible for payment. The Drug Formulary Committee may recommend drugs for prior authorization directly to the commissioner. The commissioner may also request that the Drug Formulary Committee review a drug for prior authorization.

(e) Before the commissioner requires prior authorization for a drug:

(1) the commissioner must provide the Drug Formulary Committee with information on the impact that placing the drug on prior authorization may have on the quality of patient care and on program costs and information regarding whether the drug is subject to clinical abuse or misuse if such data is available; and

(2) the Drug Formulary Committee must hold a public forum and receive public comment for an additional 15 days from the date of the public forum.

(f) Notwithstanding paragraph (e), the commissioner may automatically require prior authorization for a period not to exceed 180 days for any drug that is approved by the United States Food and Drug Administration after July 1, 2019. The 180-day period begins no later than the first day that a drug is available for shipment to pharmacies within the state. The Drug Formulary Committee shall recommend to the commissioner general criteria to use for determining prior authorization of the drugs, but the Drug Formulary Committee is not required to review each individual drug.

(g) The commissioner may also require prior authorization before nonformulary drugs are eligible for payment.

(h) Prior authorization requests must be processed in accordance with Code of Federal Regulations, title 45, section 156.122.

Subd. 3. **Pharmacy provider participation.** (a) A pharmacy enrolled to dispense prescription drugs to medical assistance enrollees under section 256B.0625 must participate as a provider in the MinnesotaCare outpatient prescription drug program.

(b) A pharmacy that is enrolled to dispense prescription drugs to MinnesotaCare enrollees is not permitted to refuse service to an enrollee unless:

(1) the pharmacy does not have a prescription drug in stock and cannot obtain the drug in time to treat the enrollee's medical condition;

(2) the enrollee is unable or unwilling to pay the enrollee's co-payment at the time the drug is dispensed;

(3) after performing drug utilization review, the pharmacist identifies the prescription drug as being a therapeutic duplication, having a drug-disease contraindication, having a drug-drug interaction, having been prescribed for the incorrect dosage or duration of treatment, having a drug-allergy interaction, or having issues related to clinical abuse or misuse by the enrollee;

(4) the prescription drug is not covered by MinnesotaCare; or

(5) dispensing the drug would violate a provision of chapter 151.

Subd. 4. **Covered outpatient prescription drug reimbursement rate.** (a) The basis for determining the amount of payment shall be the lowest of the National Average Drug Acquisition Cost; the maximum allowable cost established under section 256B.0625, subdivision 13e, plus a fixed dispensing fee; or the usual and customary price. The fixed dispensing fee shall be $1.50 for covered outpatient prescription drugs.

(b) The basis for determining the amount of payment for a pharmacy that acquires drugs through the federal 340B Drug Pricing Program shall be the lowest of (1) the National Average Drug Acquisition Cost minus 30 percent; (2) the maximum allowable cost established under section 256B.0625, subdivision 13e, minus 30 percent, plus a fixed dispensing fee; or (3) the usual and customary price. The fixed dispensing fee shall be $1.50 for covered outpatient prescription drugs.

(c) For purposes of this subdivision, the usual and customary price is the lowest price charged by the provider to a patient who pays for the prescription by cash, check, or charge account and includes the prices the pharmacy charges to customers enrolled in a prescription savings club or prescription discount club administered by the pharmacy, pharmacy chain, or contractor to the provider.

EFFECTIVE DATE. This section is effective January 1, 2022.

Sec. 10. **[256T.01] PURPOSE.**

(a) The legislature finds that the staggering growth in health care costs is having a devastating effect on the health and cost of living of Minnesota residents. The legislature further finds that the number of uninsured and underinsured residents is growing each year and that the cost of health care coverage for our insured residents often far exceeds their ability to pay.

(b) The legislature further finds that it must enact immediate and intensive cost containment measures to limit the growth of health care expenditures, reform insurance practices, and finance a plan that offers access to affordable health care for Minnesota residents by capturing dollars now lost to inefficiencies in Minnesota's health care system.

(c) The legislature further finds that providing affordable access to health care is essential to quality of life in Minnesota.

(d) It is, therefore, the intent of the legislature to establish the OneCare Buy-In to address the immediate challenges of affordability and access related to prescription drugs and dental care and to offer comprehensive coverage options that establish contingencies for failures in the individual market.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 11. **[256T.02] DEFINITIONS.**

Subdivision 1. **Application.** For purposes of this chapter, the terms in this section have the meanings given.

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of human services.

Subd. 3. **Department.** "Department" means the Department of Human Services.

Subd. 4. **Essential health benefits.** "Essential health benefits" has the meaning given in section 62Q.81, subdivision 4.

Subd. 5. **Individual market.** "Individual market" has the meaning given in section 62A.011, subdivision 5.

Subd. 6. **MNsure website.** "MNsure website" has the meaning given in section 62V.02, subdivision 13.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 12. **[256T.03] ONECARE BUY-IN.**

Subdivision 1. **Establishment.** (a) The commissioner shall establish a program consistent with this section to offer products developed for the OneCare Buy-In through the MNsure website.

(b) The commissioner, in collaboration with the commissioner of commerce and the MNsure Board, shall:

(1) establish a cost allocation methodology to reimburse MNsure operations in lieu of the premium withhold for qualified health plans under section 62V.05;

(2) implement mechanisms to ensure the long-term financial sustainability of Minnesota's public health care programs and mitigate any adverse financial impacts to the state and MNsure. These mechanisms must minimize adverse selection, state financial risk and contribution, and negative impacts to premiums in the individual and group health insurance markets; and

(3) coordinate eligibility and coverage to ensure that persons, to the extent possible, transitioning between medical assistance, MinnesotaCare, and the OneCare Buy-In have continuity of care.

(c) The OneCare Buy-In shall be considered: (1) a public health care program for purposes of chapter 62V; and (2) the MinnesotaCare program for purposes of requirements for health maintenance organizations under section 62D.04, subdivision 5, and providers under section 256B.0644.

(d) The Department of Human Services is deemed to meet and receive certification and authority under section 62D.03 and be in compliance with sections 62D.01 to 62D.30. The

commissioner has the authority to accept and expend all federal funds made available under this chapter upon federal approval.

Subd. 2. **Premium administration and payment.** (a) The commissioner shall establish annually a per-enrollee monthly premium rate. The commissioner shall publish the premium rate by August 1 of each year.

(b) OneCare Buy-In premium administration shall be consistent with requirements under the federal Affordable Care Act for qualified health plan premium administration. Premium rates shall be established in accordance with section 62A.65, subdivision 3.

Subd. 3. **Rates to providers.** The commissioner shall establish rates for provider payments that are targeted to the current rates established under chapter 256L, plus the aggregate difference between those rates and Medicare rates. The aggregate must not consider services that receive a Medicare encounter payment.

Subd. 4. **Reserve requirements.** A OneCare Buy-In reserve account is established in the state treasury. Enrollee premiums collected under subdivision 2 shall be deposited into the reserve account. The reserve account shall be used to cover expenditures related to operation of the OneCare Buy-In, including the payment of claims and all other accrued liabilities. No other account within the state treasury shall be used to finance the reserve account except as otherwise specified in state law.

Subd. 5. **Covered benefits.** Each health plan established under this chapter must include the essential health benefits package required under section 1302(a) of the Affordable Care Act and as described in section 62Q.81; dental services described in section 256B.0625, subdivision 9, paragraphs (b) and (c); and vision services described in Minnesota Rules, part 9505.0277, and may include other services under section 256L.03, subdivision 1.

Subd. 6. **Third-party administrator.** (a) The commissioner may enter into a contract with a third-party administrator to perform the operational management of the OneCare Buy-In. Duties of the third-party administrator include but are not limited to the following:

(1) development and distribution of plan materials for potential enrollees;

(2) receipt and processing of electronic enrollment files sent from the state;

(3) creation and distribution of plan enrollee materials including identification cards, certificates of coverage, plan formulary, provider directory, and premium billing statements;

(4) processing premium payments and sending termination notices for nonpayment to enrollees and the state;

(5) payment and adjudication of claims;

(6) utilization management;

(7) coordination of benefits;

(8) grievance and appeals activities; and

(9) fraud, waste, and abuse prevention activities.

(b) Any solicitation of vendors to serve as the third-party administrator is subject to the requirements under section 16C.06.

Subd. 7. **Eligibility.** (a) To be eligible for the OneCare Buy-In, a person must:

(1) be a resident of Minnesota; and

(2) not be eligible for government-sponsored programs as defined in United States Code, title 26, section 5000A(f)(1)(A). For purposes of this subdivision, an applicant or enrollee who is entitled to Medicare Part A or enrolled in Medicare Part B coverage under title XVIII of the Social Security Act, United States Code, title 42, sections 1395c to 1395w-152, is considered eligible for government-sponsored programs. An applicant or enrollee who is entitled to premium-free Medicare Part A shall not refuse to apply for or enroll in Medicare coverage to establish eligibility for the OneCare Buy-In.

(b) A person who is determined eligible for enrollment in a qualified health plan with or without advance payments of the premium tax credit and with or without cost-sharing reductions according to Code of Federal Regulations, title 45, section 155.305, paragraphs (a), (f), and (g), is eligible to purchase and enroll in the OneCare Buy-In instead of purchasing a qualified health plan as defined under section 62V.02.

Subd. 8. **Enrollment.** (a) A person may apply for the OneCare Buy-In during the annual open and special enrollment periods established for MNsure as defined in Code of Federal Regulations, title 45, sections 155.410 and 155.420 through the MNsure website.

(b) A person must annually reenroll for the OneCare Buy-In during open and special enrollment periods.

Subd. 9. **Premium tax credits, cost-sharing reductions, and subsidies.** A person who is eligible under this chapter, and whose income is less than or equal to 400 percent of the federal poverty guidelines, may qualify for advance premium tax credits and cost-sharing reductions under Code of Federal Regulations, title 45, section 155.305, paragraphs (a), (f), and (g), to purchase a health plan established under this chapter.

Subd. 10. **Covered benefits and payment rate modifications.** The commissioner, after providing public notice and an opportunity for public comment, may modify the covered benefits and payment rates to carry out this chapter.

Subd. 11. **Request for federal authority.** The commissioner shall seek all necessary federal waivers to establish the OneCare Buy-In under this chapter.

EFFECTIVE DATE. (a) Subdivisions 1 to 10 are effective January 1, 2023.

(b) Subdivision 11 is effective the day following final enactment.

Sec. 13. **[256T.04] ONECARE BUY-IN PRODUCTS.**

Subdivision 1. **Platinum product.** The commissioner of human services shall establish a OneCare Buy-In coverage option that provides platinum level of coverage in accordance with the Affordable Care Act and benefits that are actuarially equivalent to 90 percent of the full actuarial value of the benefits provided under the OneCare Buy-In coverage option. This product must be made available in all rating areas in the state.

Subd. 2. **Silver and gold products.** (a) If any rating area lacks an affordable or comprehensive health care coverage option according to standards developed by the commissioner of health, the following year the commissioner of human services shall offer silver and gold products established under paragraph (b) in the rating area for a five-year period. Notwithstanding section 62U.04, subdivision 11, the commissioner of health may use data collected under section 62U.04, subdivisions 4 and 5, to monitor triggers in the individual market under this chapter. Effective January 1, 2020, the commissioner of health may require submission of additional data elements under section 62U.04, subdivisions 4 and 5, in a manner specified by the commissioner, to conduct the analysis necessary to monitor the individual market under this chapter.

(b) The commissioner shall establish the following OneCare Buy-In coverage options: one coverage option shall provide silver level of coverage in accordance with the Affordable Care Act and benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the OneCare Buy-In coverage option, and one coverage option shall provide gold level of coverage in accordance with the Affordable Care Act and benefits that are actuarially equivalent to 80 percent of the full actuarial value of the benefits provided under the OneCare Buy-In coverage option.

Subd. 3. **Qualified health plan rules.** (a) The coverage options developed under this section are subject to the process under section 62K.06. The coverage options developed

under this section are deemed to meet requirements of chapters 62A, 62K, and 62V that apply to qualified health plans.

(b) Notwithstanding any other law to the contrary, benefits under this section are secondary to a plan of insurance or benefit program under which an eligible person may have coverage. The commissioner shall use cost-avoidance techniques to coordinate any other health coverage for eligible persons and identify eligible persons who may have coverage or benefits under other plans of insurance.

(c) The Department of Human Services is not an insurance company for purposes of this chapter.

Subd. 4. **Actuarial value.** Determination of the actuarial value of coverage options under this section must be calculated in accordance with Code of Federal Regulations, title 45, section 156.135.

EFFECTIVE DATE. This section is effective January 1, 2023.

Sec. 14. **[256T.30] OUTPATIENT PRESCRIPTION DRUGS.**

Subdivision 1. **Establishment of program.** The commissioner shall administer and oversee the outpatient prescription drug program. The commissioner shall not include the outpatient pharmacy benefit in a contract with a public or private entity.

Subd. 2. **Covered outpatient prescription drugs.** Outpatient prescription drugs are covered in accordance with chapter 256L.

Subd. 3. **Pharmacy provider participation.** (a) A pharmacy enrolled to dispense prescription drugs to medical assistance enrollees under section 256B.0625 must participate as a provider in the outpatient prescription drug program under this section.

(b) A pharmacy that is enrolled to dispense prescription drugs under this section is not permitted to refuse service to an enrollee unless:

(1) the pharmacy does not have a prescription drug in stock and cannot obtain the drug in time to treat the enrollee's medical condition;

(2) the enrollee is unable or unwilling to pay the enrollee's co-payment at the time the drug is dispensed;

(3) after performing drug utilization review, the pharmacist identifies the prescription drug as being a therapeutic duplication, having a drug-disease contraindication, having a drug-drug interaction, having been prescribed for the incorrect dosage or duration of

treatment, having a drug-allergy interaction, or having issues related to clinical abuse or misuse by the enrollee;

(4) the prescription drug is not covered by the plan; or

(5) dispensing the drug would violate a provision of chapter 151.

Subd. 4. **Reimbursement rate.** The commissioner shall establish outpatient prescription drug reimbursement rates according to chapter 256L.

EFFECTIVE DATE. This section is effective January 1, 2023.

Sec. 15. **DIRECTION TO COMMISSIONER; STATE-BASED RISK ADJUSTMENT ANALYSIS.**

The commissioner of commerce, in consultation with the commissioner of health, shall conduct a study on the design and implementation of a state-based risk adjustment program. The commissioner shall report on the findings of the study and any recommendations to the legislative committees with jurisdiction over the individual health insurance market by February 15, 2021.

Sec. 16. **REPEALER.**

Minnesota Statutes 2018, section 256L.11, subdivision 6a, is repealed.

EFFECTIVE DATE. This section is effective January 1, 2022.

ARTICLE 10
OPIOIDS

Section 1. Minnesota Statutes 2018, section 151.01, is amended by adding a subdivision to read:

Subd. 2b. **Chain pharmacy.** "Chain pharmacy" means any pharmacy that is part of a group of ten or more establishments that (1) conduct business under the same business name, or (2) operate under common ownership or management or pursuant to a franchise agreement with the same franchisor.

Sec. 2. Minnesota Statutes 2018, section 151.01, is amended by adding a subdivision to read:

Subd. 42. **Unit.** "Unit" means, with respect to a particular drug product, the individual dosage form of the drug product that is most commonly prescribed to a patient, including but not limited to tablet, capsule, patch, syringe, milliliter, or gram.

Sec. 3. Minnesota Statutes 2018, section 151.065, is amended by adding a subdivision to read:

Subd. 3a. **Controlled substance registration fees.** (a) Initial and annual renewal controlled substance registration fees are as follows:

(1) controlled substance drug manufacturer, large, $75,000;

(2) controlled substance drug manufacturer, medium, $5,000;

(3) controlled substance drug manufacturer, small, $500;

(4) drug wholesaler distributing controlled substances, large, $75,000;

(5) drug wholesaler distributing controlled substances, small, $2,500;

(6) pharmacy dispensing controlled substances, other than hospital or chain pharmacy, $2,500;

(7) pharmacy other than a hospital, independent, $500;

(8) pharmacy, hospital (50 or more beds), $2,500;

(9) pharmacy, hospital (fewer than 50 beds), $500;

(10) practitioner prescribing, administering, or dispensing controlled substances, $125; and

(11) controlled substances researcher, $125.

(b) For the purposes of this subdivision:

(1) a controlled substance drug manufacturer shall be subject to the fee established under paragraph (a), clause (1), if the data collected through the prescription monitoring program established under section 152.126 indicates that 5,000,000 or more units of the manufacturer's controlled substance products have been dispensed to residents of this state during the previous calendar year;

(2) a controlled substance drug manufacturer shall be subject to the fee established under paragraph (a), clause (2), if the data collected through the prescription monitoring program

established under section 152.126 indicates that more than 1,000,000 but less than 5,000,000 units of the manufacturer's controlled substance products have been dispensed to residents of this state during the previous calendar year;

(3) a controlled substance drug manufacturer shall be subject to the fee established under paragraph (a), clause (3), if the data collected through the prescription monitoring program established under section 152.126 indicates that 1,000,000 or fewer units of the manufacturer's controlled substance products have been dispensed to residents of this state during the previous calendar year;

(4) a wholesaler of controlled substances shall be subject to the fee established under paragraph (a), clause (4), if the data collected pursuant to section 152.10, subdivision 4, indicates that the wholesaler has distributed 5,000,000 or more units of controlled substances within or into this state; and

(5) a wholesaler of controlled substances shall be subject to the fee established under paragraph (a), clause (5), if the data collected pursuant to section 152.10, subdivision 4, indicates that the wholesaler has distributed less than 5,000,000 units of controlled substances within or into this state.

Sec. 4. Minnesota Statutes 2018, section 151.252, subdivision 1, is amended to read:

Subdivision 1. **Requirements.** (a) No person shall act as a drug manufacturer without first obtaining a license from the board and paying any applicable fee specified in section 151.065.

(b) In addition to the license required under paragraph (a), a manufacturer of a Schedule II through IV opiate controlled substance must pay the applicable registration fee specified in section 151.77, subdivision 3, by June 1 of each year, beginning June 1, 2020. In the event of a change of ownership of the manufacturer, the new owner must pay the registration fee specified under section 151.77, subdivision 3, that the original owner would have been assessed had it retained ownership. The board may assess a late fee of ten percent per month for every portion of a month that the registration fee is paid after the due date.

~~(b)~~ (c) Application for a drug manufacturer license under this section shall be made in a manner specified by the board.

~~(c)~~ (d) No license shall be issued or renewed for a drug manufacturer unless the applicant agrees to operate in a manner prescribed by federal and state law and according to Minnesota Rules.

~~(d)~~ (e) No license shall be issued or renewed for a drug manufacturer that is required to be registered pursuant to United States Code, title 21, section 360, unless the applicant supplies the board with proof of registration. The board may establish by rule the standards for licensure of drug manufacturers that are not required to be registered under United States Code, title 21, section 360.

~~(e)~~ (f) No license shall be issued or renewed for a drug manufacturer that is required to be licensed or registered by the state in which it is physically located unless the applicant supplies the board with proof of licensure or registration. The board may establish, by rule, standards for the licensure of a drug manufacturer that is not required to be licensed or registered by the state in which it is physically located.

~~(f)~~ (g) The board shall require a separate license for each facility located within the state at which drug manufacturing occurs and for each facility located outside of the state at which drugs that are shipped into the state are manufactured.

~~(g)~~ (h) The board shall not issue an initial or renewed license for a drug manufacturing facility unless the facility passes an inspection conducted by an authorized representative of the board. In the case of a drug manufacturing facility located outside of the state, the board may require the applicant to pay the cost of the inspection, in addition to the license fee in section 151.065, unless the applicant furnishes the board with a report, issued by the appropriate regulatory agency of the state in which the facility is located or by the United States Food and Drug Administration, of an inspection that has occurred within the 24 months immediately preceding receipt of the license application by the board. The board may deny licensure unless the applicant submits documentation satisfactory to the board that any deficiencies noted in an inspection report have been corrected.

Sec. 5. Minnesota Statutes 2018, section 151.47, is amended by adding a subdivision to read:

Subd. 1a. **Controlled substance wholesale drug distributor requirements.** In addition to the license required under subdivision 1, a wholesale drug distributor distributing a Schedule II through IV opiate controlled substance must pay the applicable registration fee specified in section 151.77, subdivision 4, by June 1 of each year beginning June 1, 2020. In the event of a change in ownership of the wholesale drug distributor, the new owner must pay the registration fee specified in section 151.77, subdivision 4, that the original owner would have been assessed had it retained ownership. The board may assess a late fee of ten percent per month for every portion of a month that the registration fee is paid after the due date.

Sec. 6. **[151.77] OPIATE PRODUCT REGISTRATION FEE.**

Subdivision 1. **Definitions.** For purposes of this section, the following terms have the meanings given them:

(1) "manufacturer" means a manufacturer licensed under section 151.252 that is engaged in the manufacturing of an opiate;

(2) "opiate" means any opiate-containing controlled substance listed in section 152.02, subdivisions 3 to 5, that is distributed, delivered, sold, or dispensed into or within this state; and

(3) "wholesaler" means a wholesale drug distributor who is licensed under section 151.47, and is engaged in the wholesale drug distribution of an opiate.

Subd. 2. **Reporting requirements.** (a) By March 1 of each year, beginning March 1, 2020, each manufacturer and each wholesale drug distributor must report to the board every sale, delivery, or other distribution within or into this state of any opiate that is made to any practitioner, pharmacy, hospital, veterinary hospital, or other person who is permitted by section 151.37 to possess controlled substances for administration or dispensing to patients that occurred during the previous calendar year. Reporting must be in the automation of reports and consolidated orders system format unless otherwise specified by the board. If a manufacturer or wholesaler fails to provide information required under this paragraph on a timely basis, the board may assess an administrative penalty of $500 per day. This penalty shall not be considered a form of disciplinary action.

(b) By March 1 of each year, beginning March 1, 2020, each owner of a pharmacy with at least one location within this state must report to the board the intracompany delivery or distribution into this state of any opiate, to the extent that those deliveries and distributions are not reported to the board by a licensed wholesale drug distributor owned by, under contract to, or otherwise operating on behalf of the owner of the pharmacy. Reporting must be in the manner and format specified by the board for deliveries and distributions that occurred during the previous calendar year. The report must include the name of the manufacturer or wholesaler from which the owner of the pharmacy ultimately purchased the opiate, and the amount and date that the purchases occurred.

Subd. 3. **Determination of each manufacturer's registration fee.** (a) The board shall annually assess manufacturer registration fees that in an aggregate amount total $12,000,000. The board shall determine each manufacturer's annual registration fee that is prorated and based on the manufacturer's percentage of the total number of units reported to the board under subdivision 2.

(b) By April 1 of each year, beginning April 1, 2020, the board shall notify each manufacturer of the annual amount of the manufacturer's registration fee to be paid by June 1, in accordance with section 151.252, subdivision 1, paragraph (b).

(c) In conjunction with the data reported under this section, and notwithstanding section 152.126, subdivision 6, the board may use the data reported under section 152.126, subdivision 4, to determine the manufacturer registration fees required under this subdivision.

(d) A manufacturer may dispute the registration fee as determined by the board no later than 30 days after the date of notification; however, the manufacturer must still remit the fee as required by section 151.252, subdivision 1, paragraph (b). The dispute must be filed with the board in the manner and using the forms specified by the board. A manufacturer must submit, with the required forms, data satisfactory to the board that demonstrates that the registration fee was incorrect. The board must make a decision concerning a dispute no later than 60 days after receiving the required dispute forms. If the board determines that the manufacturer has satisfactorily demonstrated that the original fee was incorrect, the board must adjust the manufacturer's registration fee due the next year by the amount that is in excess of the correct fee that should have been paid.

Subd. 4. **Determination of each wholesaler's registration fee.** (a) The board shall annually assess wholesaler registration fees that in an aggregate amount total $8,000,000. The board shall determine each wholesaler's annual registration fee that is prorated and based on the wholesaler's percentage of the total number of units reported to the board under subdivision 2. This paragraph does not apply to a wholesaler if the wholesaler is also licensed as a drug manufacturer under section 151.252.

(b) By April 1 of each year, beginning April 1, 2020, the board shall notify each wholesaler of the annual amount of the wholesaler's registration fee to be paid by June 1, in accordance with section 151.47, subdivision 1a.

(c) A wholesaler may dispute the registration fee as determined by the board no later than 30 days after the date of notification. However, the wholesaler must still remit the fee as required by section 151.47, subdivision 1a. The dispute must be filed with the board in the manner and using the forms specified by the board. A wholesaler must submit, with the required forms, data satisfactory to the board that demonstrates that the registration fee was incorrect. The board must make a decision concerning a dispute no later than 60 days after receiving the required dispute forms. If the board determines that the wholesaler has satisfactorily demonstrated that the original fee was incorrect, the board must adjust the

wholesaler's registration fee due the next year by the amount that is in excess of the correct fee that should have been paid.

Subd. 5. **Report.** (a) The Board of Pharmacy shall evaluate the registration fee on drug manufacturers and wholesalers established under this section, and whether the fee has impacted the prescribing practices for opiates by reducing the number of opiate prescriptions issued during calendar years 2020, 2021, and 2022, to the extent the board has the ability to effectively identify a correlation. Notwithstanding section 152.126, subdivision 6, the board may access the data reported under section 152.126, subdivision 4, to conduct this evaluation.

(b) The board shall submit the results of its evaluation to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by March 1, 2023.

Subd. 6. **Legislative review.** The legislature shall review the reports from the Opioid Addiction Advisory Council under section 151.255, subdivision 1, paragraph (c), the report from the Board of Pharmacy under subdivision 5, and any other relevant report or information related to the opioid crisis in Minnesota, to make a determination about whether the opiate product registration fee assessed under this section should continue beyond July 1, 2023.

Sec. 7. Minnesota Statutes 2018, section 152.01, is amended by adding a subdivision to read:

Subd. 25. **Practitioner.** "Practitioner" has the meaning given in section 151.01, subdivision 23.

Sec. 8. Minnesota Statutes 2018, section 152.10, is amended to read:

152.10 ~~SALES, PERSONS ELIGIBLE~~ CONTROLLED SUBSTANCE REGISTRATION.

Subdivision 1. **Generally.** No person ~~other than a licensed pharmacist, assistant pharmacist or pharmacist intern under the supervision of a pharmacist~~ shall sell a ~~stimulant or depressant drug and then only as provided in sections 152.021 to 152.12 and 152.0262.~~ controlled substance except (1) as provided in this chapter, and (2) when any registration required under this section has been obtained and is active.

Subd. 2. **Registration requirement.** (a) A person must obtain a registration issued by the Board of Pharmacy in order to:

(1) manufacture, distribute, prescribe, or dispense any controlled substance within the state;

(2) propose to engage in the manufacture, distribution, prescription, or dispensing of any controlled substance within the state;

(3) dispense, distribute, or propose to dispense or distribute any controlled substance for use in the state by shipping, mailing, or otherwise delivering the controlled substance from a location outside this state; or

(4) use or propose to use controlled substances in the course of a bona fide research project.

(b) Persons registered by the Board of Pharmacy under this section to manufacture, distribute, prescribe, dispense, store, or conduct research with controlled substances may possess, manufacture, distribute, prescribe, dispense, store, or conduct research with the controlled substances to the extent authorized by the registration and in conformity with this section. Registered persons must also comply with any other statutes or rules applicable to the manufacture, distribution, prescribing, dispensing, or storage of, or research with, prescription drugs.

(c) Except as otherwise provided by law, the following persons and entities are not required to register and may lawfully possess controlled substances under this chapter:

(1) an agent or employee of any registered manufacturer, registered drug wholesaler, or registered pharmacy while acting in the course of employment only;

(2) a common carrier, or an employee of a common carrier, whose possession of a controlled substance is in the usual course of the person's business or employment;

(3) a licensed hospital or other licensed institution where sick and injured persons are cared for or treated, bona fide hospitals where animals are treated, or employees of a licensed hospital or institution acting in the course of employment, except that (i) employees who are licensed practitioners must be registered to the extent that they engage in the prescribing of controlled substances, and (ii) hospital pharmacies licensed by the board must be registered;

(4) a licensed or registered health care professional who acts as the authorized agent of a practitioner and who administers controlled substances at the direction of the practitioner, provided that the practitioner is authorized to prescribe controlled substances pursuant to section 152.12;

(5) an analytical laboratory, or employee of an analytical laboratory when acting in the course of employment, when conducting an anonymous analysis service and when the analytical laboratory is registered by the federal Drug Enforcement Administration;

(6) a medical cannabis manufacturer registered under section 152.25;

(7) a person in possession of any controlled substance prescribed for that person pursuant to section 152.12, subdivision 1, or obtained pursuant to the requirements of the medical cannabis program established under this chapter; or

(8) the owner of an animal for which a controlled substance has been prescribed pursuant to section 152.12, subdivision 2.

(d) Nothing in this section prohibits a person for whom a controlled substance has been dispensed in accordance with a prescription issued pursuant to section 152.12 from designating a family member, caregiver, or other individual to assist the person in obtaining or administering the controlled substance, or disposing of the controlled substance pursuant to section 152.105.

(e) A separate registration is required at each principal place of business or professional practice where the applicant manufactures, distributes, prescribes, dispenses, or conducts research with controlled substances. This paragraph does not apply to an office used by a practitioner who is registered at another location, where controlled substances are prescribed but neither administered nor otherwise dispensed as a regular part of the professional practice of the practitioner at the office, and where no supplies of controlled substances are maintained.

(f) The Board of Pharmacy, through its authorized representative, has the authority to inspect the establishment of a registrant or applicant for registration. This authority is granted for routine inspections and for the purpose of conducting investigations of complaints made against registrants.

(g) The board may require a registrant to submit documents or written statements of fact relevant to a registration that the board deems necessary to determine whether the registration should be granted or denied. If the registrant fails to provide the documents or statements within a reasonable time after being requested to do so, the registrant shall be deemed to have waived the opportunity to present the documents or statements for consideration by the board in granting or denying the registration.

(h) Failure to renew the controlled substance registration on a timely basis shall cause the registration to be automatically forfeited. A forfeited registration may be reinstated pursuant to section 151.065, subdivision 7.

Subd. 3. **Registration.** (a) The Board of Pharmacy shall register an applicant to manufacture, dispense, prescribe, distribute, or conduct research with controlled substances included in section 152.02, subdivisions 3 to 6, unless it determines that the issuance of that registration would be inconsistent with the public interest. In determining the public interest, the board shall consider the following factors:

(1) maintaining effective controls against diversion of controlled substances into other than legitimate medical, scientific, or industrial channels;

(2) complying with applicable federal, state, and local law;

(3) whether the applicant has been convicted under any federal or state laws relating to any controlled substance;

(4) past experience in the manufacture, distribution, or dispensing of controlled substances or in research involving controlled substances, and the existence in the applicant's establishment of effective controls against diversion;

(5) whether the applicant has furnished false or fraudulent material in any application filed under this chapter;

(6) suspension or revocation of the applicant's federal registration to manufacture, distribute, prescribe, dispense, or conduct research with controlled substances as authorized by federal law; and

(7) any other factor relevant to and consistent with public health and safety.

(b) Registration under paragraph (a) does not entitle a registrant to manufacture, dispense, prescribe, and distribute controlled substances included in section 152.02, subdivision 2. Manufacturing, dispensing, prescribing, and distribution of controlled substances included in section 152.02, subdivision 2, may only occur as part of a bona fide research project pursuant to section 152.12, subdivision 3, or 152.21 and as allowed under federal law and regulations. However, medical cannabis, as defined in section 152.22, subdivision 6, may be produced and distributed as allowed under section 152.29.

(c) A practitioner must be registered under this section in order to dispense or prescribe any controlled substances included in section 152.02, subdivisions 3 to 6.

Subd. 4. **Revocation and suspension of registration.** (a) A registration under this section to manufacture, dispense, prescribe, distribute, or conduct research with a controlled substance may be suspended or revoked by the Board of Pharmacy upon finding probable cause that the registrant has:

(1) furnished false or fraudulent material information in any application filed under this chapter;

(2) been convicted of a felony pursuant to any state or federal law relating to any controlled substance;

(3) had the registrant's federal controlled substance registration to manufacture, distribute, prescribe, dispense, or conduct research with controlled substances suspended or revoked;

(4) had the registrant's state license to practice the registrant's profession suspended or revoked by the applicable health-related licensing board;

(5) had the registrant's state license to practice the registrant's profession placed on conditional status by the applicable health-related licensing board when the conditions prohibit the registrant from prescribing, administering, dispensing, or otherwise handling controlled substances; or

(6) violated federal or state statutes or regulations related to the manufacture, distribution, prescribing, dispensing, or research of a controlled substance in a manner that places the public at imminent risk of serious harm.

(b) The Board of Pharmacy may limit revocation or suspension of a registration to the particular controlled substance with respect to which grounds for revocation or suspension exist.

Subd. 5. **Reporting.** On at least a quarterly basis, drug wholesalers must report to the board all distributions, within or into the state, of all Schedule II controlled substance products, and of all Schedule III controlled substance products that contain narcotics or gamma hydroxybutyric acid. Reporting must be in the automation of reports and consolidated orders system format unless otherwise specified by the board. This reporting shall also meet any other requirement for reporting distribution data to the board found in this chapter or in chapter 151.

Sec. 9. Minnesota Statutes 2018, section 152.11, subdivision 1, is amended to read:

Subdivision 1. **General prescription requirements for controlled substances.** (a) A written prescription or an oral prescription reduced to writing, when issued for a controlled

substance in Schedule II, III, IV, or V, is void unless: (1) it is written in ink and contains the name and address of the person for whose use it is intended; (2) it states the amount of the controlled substance to be ~~compounded or~~ dispensed, with directions for its use; (3) if a written prescription, it contains the handwritten signature of the prescriber, the prescriber's address, ~~and federal registry number of the prescriber~~ and a designation of the branch of the healing art pursued by the prescriber; and if an oral prescription, the name and address of the prescriber and a designation of the prescriber's branch of the healing art; ~~and~~ (4) it shows the date when signed by the prescriber, or the date of acceptance in the pharmacy if an oral prescription~~.~~; and (5) it includes the prescriber's current state and federal controlled substance registration numbers.

(b) An electronic prescription for a controlled substance in Schedule II, III, IV, or V is void unless: (1) it complies with the standards established pursuant to section 62J.497 and with those portions of Code of Federal Regulations, title 21, parts 1300, 1304, 1306, and 1311, that pertain to electronic prescriptions~~.~~; and (2) it includes the prescriber's current state controlled substance registration number.

(c) A prescription for a controlled substance in Schedule II, III, IV, or V that is transmitted by facsimile, either computer to facsimile machine or facsimile machine to facsimile machine, is void unless: (1) it complies with the applicable requirements of Code of Federal Regulations, title 21, part 1306~~.~~; and (2) it includes the prescriber's current state controlled substance registration number.

(d) Every licensed pharmacy that dispenses a controlled substance prescription shall retain the original prescription in a file for a period of not less than two years, open to inspection by any officer of the state, county, or municipal government whose duty it is to aid and assist with the enforcement of this chapter. An original electronic or facsimile prescription may be stored in an electronic database, provided that the database provides a means by which original prescriptions can be retrieved, as transmitted to the pharmacy, for a period of not less than two years.

(e) Every licensed pharmacy shall distinctly label the container in which a controlled substance is dispensed with the directions contained in the prescription for the use of that controlled substance.

Sec. 10. Minnesota Statutes 2018, section 152.11, subdivision 1a, is amended to read:

Subd. 1a. **Prescription requirements for Schedule II controlled substances.** (a) No person may dispense a controlled substance included in Schedule II of section 152.02 without a prescription issued by (1) a ~~doctor of medicine, a doctor of osteopathic medicine licensed~~

~~to practice medicine, a doctor of dental surgery, a doctor of dental medicine, a doctor of podiatry, or a doctor of veterinary medicine,~~ practitioner lawfully licensed to prescribe in this state, acting within the practitioner's scope of practice, and having a current federal controlled substance registration number and a state controlled substance registration number issued pursuant to section 152.10, or ~~by~~ (2) a practitioner licensed to prescribe controlled substances by the state in which the prescription is issued, and having a current federal ~~Drug Enforcement Administration~~ controlled substance registration number and, if required, a controlled substance registration number issued by the other state.

(b) The prescription must either be printed or written in ink and contain the handwritten signature of the prescriber or be transmitted electronically or by facsimile as permitted under subdivision 1. Provided that in emergency situations, as authorized by federal law, such drug may be dispensed upon oral prescription reduced promptly to writing and filed by the pharmacist. Such prescriptions shall be retained in conformity with section 152.101. No prescription for a Schedule II substance may be refilled.

Sec. 11. Minnesota Statutes 2018, section 152.11, subdivision 2, is amended to read:

Subd. 2. **Prescription requirements for Schedule III or IV controlled substances.** (a) No person may dispense a controlled substance included in Schedule III or IV of section 152.02 without a prescription issued, as permitted under subdivision 1, by (1) a ~~doctor of medicine, a doctor of osteopathic medicine licensed to practice medicine, a doctor of dental surgery, a doctor of dental medicine, a doctor of podiatry, a doctor of optometry limited to Schedule IV, or a doctor of veterinary medicine,~~ practitioner lawfully licensed to prescribe in this state, acting within the practitioner's scope of practice, and having a current federal controlled substance registration number and a state controlled substance registration number issued pursuant to section 152.10, or ~~from~~ (2) a practitioner licensed to prescribe controlled substances by the state in which the prescription is issued, and having a current federal ~~drug enforcement administration~~ controlled substance registration number and, if required, a controlled substance registration number issued by the other state.

(b) Such prescription may not be dispensed or refilled except with the documented consent of the prescriber, and in no event more than six months after the date on which such prescription was issued and no such prescription may be refilled more than five times.

Sec. 12. Minnesota Statutes 2018, section 152.11, subdivision 2a, is amended to read:

Subd. 2a. **Federal and state registration number exemption.** A prescription need not bear a federal drug enforcement administration registration number ~~that authorizes the~~

~~prescriber to prescribe controlled substances~~ or a state controlled substance registration number if the drug prescribed is not a controlled substance in Schedule II, III, IV, or V. No person shall impose a requirement inconsistent with this subdivision.

Sec. 13. Minnesota Statutes 2018, section 152.11, subdivision 2b, is amended to read:

Subd. 2b. **Restriction on release of federal and state registration number.** No person or entity may offer for sale, sell, lease, or otherwise release a federal drug enforcement administration registration number or a state controlled substance registration number for any reason, except for drug enforcement purposes authorized by this chapter and the federal controlled substances registration system. For purposes of this section, an entity includes a state governmental agency or regulatory board, a health plan company as defined under section 62Q.01, subdivision 4, a managed care organization as defined under section 62Q.01, subdivision 5, or any other entity that maintains prescription data.

Sec. 14. Minnesota Statutes 2018, section 152.11, subdivision 2c, is amended to read:

Subd. 2c. **Restriction on use of federal and state registration number.** No entity may use a federal drug enforcement administration registration number or a state controlled substance registration number to identify or monitor the prescribing practices of a prescriber to whom that number has been assigned, except for drug enforcement purposes authorized by this chapter and the federal controlled substances registration system. For purposes of this section, an entity includes a health plan company as defined under section 62Q.01, subdivision 4, a managed care organization as defined under section 62Q.01, subdivision 5, or any other entity that maintains prescription data.

Sec. 15. Minnesota Statutes 2018, section 152.12, subdivision 1, is amended to read:

Subdivision 1. **Prescribing, dispensing, administering controlled substances in Schedules II through V.** A ~~licensed doctor of medicine, a doctor of osteopathic medicine, duly licensed to practice medicine, a doctor of dental surgery, a doctor of dental medicine, a licensed doctor of podiatry, a licensed advanced practice registered nurse, or a licensed doctor of optometry limited to Schedules IV and V, and~~ practitioner in the course of professional practice ~~only~~ and within the practitioner's scope of practice, may prescribe, administer, and dispense a controlled substance included in Schedules II through V of section 152.02, may cause the same to be administered by a nurse, an intern or an assistant under the direction and supervision of the ~~doctor~~ practitioner, and may cause a person who is an appropriately certified and licensed health care professional to prescribe and administer the same within the expressed legal scope of the person's practice as defined in Minnesota

Statutes. An individual who prescribes under this subdivision must be registered pursuant to section 152.10 and must have a current federal controlled substance registration number.

Sec. 16. Minnesota Statutes 2018, section 152.12, subdivision 2, is amended to read:

Subd. 2. **Doctor of veterinary medicine.** A licensed doctor of veterinary medicine who is registered pursuant to section 152.10 and who has a current federal controlled substance registration number, in good faith, and in the course of professional practice only, and not for use by a human being, may prescribe, administer, and dispense a controlled substance included in Schedules II through V of section 152.02, and may cause the same to be administered by an assistant under the direction and supervision of the doctor.

Sec. 17. Minnesota Statutes 2018, section 152.12, subdivision 3, is amended to read:

Subd. 3. **Research project use of controlled substances.** Any qualified person may use controlled substances in the course of a bona fide research project but cannot administer or dispense such drugs to human beings unless such drugs are prescribed, dispensed and administered by a person lawfully authorized to do so. Every person who engages in research involving the use of such substances ~~shall apply annually for registration by~~ must register with the ~~state~~ Board of Pharmacy ~~and shall pay any applicable fee specified in section 151.065, provided that such registration shall not be required if the person is covered by and has complied with federal laws covering such research projects~~ pursuant to section 152.10.

Sec. 18. Minnesota Statutes 2018, section 152.12, subdivision 4, is amended to read:

Subd. 4. **Sale of controlled substances not prohibited for certain persons and entities.** (a) Provided that the registration requirements in section 152.10 are met, nothing in this chapter shall prohibit the sale to, or the possession of, a controlled substance in Schedule II, III, IV or V by: ~~Registered~~ licensed drug wholesalers, ~~registered~~ licensed manufacturers, ~~registered~~ licensed pharmacies, or any licensed hospital or other licensed institutions wherein sick and injured persons are cared for or treated, or bona fide hospitals wherein animals are treated; or by licensed pharmacists~~,~~ or licensed ~~doctors of medicine, doctors of osteopathic medicine duly licensed to practice medicine, licensed doctors of dental surgery, licensed doctors of dental medicine, licensed doctors of podiatry, licensed doctors of optometry limited to Schedules IV and V, or licensed doctors of veterinary medicine when such~~ practitioners ~~use controlled substances~~ acting within the course and scope of their professional practice only.

(b) Provided that the registration requirements in section 152.10 are met, nothing in this chapter shall prohibit the possession of a controlled substance in Schedule II, III, IV or V by an employee or agent of a ~~registered~~ licensed drug wholesaler, ~~registered~~ licensed manufacturer, or ~~registered~~ licensed pharmacy, while acting in the course of employment; by a patient of a licensed ~~doctor of medicine, a doctor of osteopathic medicine duly licensed to practice medicine, a licensed doctor of dental surgery, a licensed doctor of dental medicine, or a licensed doctor of optometry limited to Schedules IV and V~~ practitioner; or by the owner of an animal for which a controlled substance has been prescribed by a licensed doctor of veterinary medicine, when such controlled substances are prescribed and dispensed according to law.

Sec. 19. Minnesota Statutes 2018, section 152.125, subdivision 2, is amended to read:

Subd. 2. **Prescription and administration of controlled substances for intractable pain.** Notwithstanding any other provision of this chapter, a ~~physician~~ practitioner lawfully licensed to prescribe controlled substances in this state and registered pursuant to section 152.10 may prescribe or administer a controlled substance in Schedules II to V of section 152.02 to an individual in the course of the ~~physician's~~ practitioner's treatment of the individual for a diagnosed condition causing intractable pain. No ~~physician~~ practitioner shall be subject to disciplinary action by ~~the Board of Medical Practice~~ a health-related licensing board for appropriately prescribing or administering a controlled substance in Schedules II to V of section 152.02 in the course of treatment of an individual for intractable pain, provided the ~~physician~~ practitioner keeps accurate records of the purpose, use, prescription, and disposal of controlled substances, writes accurate prescriptions, and prescribes medications in conformance with the chapter ~~147~~ of law under which the practitioner is licensed.

Sec. 20. Minnesota Statutes 2018, section 152.125, subdivision 3, is amended to read:

Subd. 3. **Limits on applicability.** This section does not apply to:

(1) a ~~physician's~~ practitioner's treatment of an individual for chemical dependency resulting from the use of controlled substances in Schedules II to V of section 152.02;

(2) the prescription or administration of controlled substances in Schedules II to V of section 152.02 to an individual whom the ~~physician~~ practitioner knows to be using the controlled substances for nontherapeutic purposes;

(3) the prescription or administration of controlled substances in Schedules II to V of section 152.02 for the purpose of terminating the life of an individual having intractable pain; or

(4) the prescription or administration of a controlled substance in Schedules II to V of section 152.02 that is not a controlled substance approved by the United States Food and Drug Administration for pain relief.

Sec. 21. Minnesota Statutes 2018, section 152.125, subdivision 4, is amended to read:

Subd. 4. **Notice of risks.** Prior to treating an individual for intractable pain in accordance with subdivision 2, a ~~physician~~ practitioner shall discuss with the individual the risks associated with the controlled substances in Schedules II to V of section 152.02 to be prescribed or administered in the course of the ~~physician's~~ practitioner's treatment of an individual, and document the discussion in the individual's record.

Sec. 22. Minnesota Statutes 2018, section 245.4661, subdivision 9, is amended to read:

Subd. 9. **Services and programs.** (a) The following three distinct grant programs are funded under this section:

(1) mental health crisis services;

(2) housing with supports for adults with serious mental illness; and

(3) projects for assistance in transitioning from homelessness (PATH program).

(b) In addition, the following are eligible for grant funds:

(1) community education and prevention;

(2) client outreach;

(3) early identification and intervention;

(4) adult outpatient diagnostic assessment and psychological testing;

(5) peer support services;

(6) community support program services (CSP);

(7) adult residential crisis stabilization;

(8) supported employment;

(9) assertive community treatment (ACT);

(10) housing subsidies;

(11) basic living, social skills, and community intervention;

(12) emergency response services;

(13) adult outpatient psychotherapy;

(14) adult outpatient medication management;

(15) adult mobile crisis services;

(16) adult day treatment;

(17) partial hospitalization;

(18) adult residential treatment;

(19) adult mental health targeted case management;

(20) intensive community rehabilitative services (ICRS); ~~and~~

(21) transportation~~.~~; and

(22) traditional healing provided to American Indians.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 23. Minnesota Statutes 2018, section 254A.03, subdivision 3, is amended to read:

Subd. 3. **Rules for substance use disorder care.** (a) The commissioner of human services shall establish by rule criteria to be used in determining the appropriate level of chemical dependency care for each recipient of public assistance seeking treatment for substance misuse or substance use disorder. Upon federal approval of a comprehensive assessment as a Medicaid benefit, or on July 1, 2018, whichever is later, and notwithstanding the criteria in Minnesota Rules, parts 9530.6600 to 9530.6655, an eligible vendor of comprehensive assessments under section 254B.05 may determine and approve the appropriate level of substance use disorder treatment for a recipient of public assistance. The process for determining an individual's financial eligibility for the consolidated chemical dependency treatment fund or determining an individual's enrollment in or eligibility for a publicly subsidized health plan is not affected by the individual's choice to access a comprehensive assessment for placement.

(b) The commissioner shall develop and implement a utilization review process for publicly funded treatment placements to monitor and review the clinical appropriateness and timeliness of all publicly funded placements in treatment.

(c) If a screen result is positive for alcohol or substance misuse, a brief screening for alcohol or substance use disorder that is provided to a recipient of public assistance within a primary care clinic, hospital, or other medical setting or school setting establishes medical necessity and approval for an initial set of substance use disorder services identified in section 254B.05, subdivision 5. The initial set of services approved for a recipient whose screen result is positive may include four hours of individual or group substance use disorder treatment, two hours of substance use disorder treatment coordination, or two hours of substance use disorder peer support services provided by a qualified individual according to chapter 245G. A recipient must obtain an assessment pursuant to paragraph (a) to be approved for additional treatment services.

EFFECTIVE DATE. Contingent upon federal approval, this section is effective July 1, 2019. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained or denied.

Sec. 24. **[256.042] OPIOID STEWARDSHIP ADVISORY COUNCIL.**

Subdivision 1. **Establishment of the advisory council.** (a) The Opioid Stewardship Advisory Council is established to develop and implement a comprehensive and effective statewide effort to address the opioid addiction and overdose epidemic in Minnesota. The council shall focus on:

(1) prevention and education, including public education and awareness for adults and youth, prescriber education, the development and sustainability of opioid overdose prevention and education programs, and providing financial support to local law enforcement agencies for opiate antagonist programs;

(2) treatment, including statewide access to effective treatment and recovery services that is aligned with Minnesota's model of care approach to promoting access to treatment and recovery services. This includes ensuring that individuals throughout the state have access to treatment and recovery services, including care coordination services; peer recovery services; medication-assisted treatment and office-based opioid treatment; integrative and multidisciplinary therapies; and culturally specific services; and

(3) innovation and capacity building, including development of evidence-based practices and using research and evaluation to understand which policies and programs promote efficient and effective prevention, treatment, and recovery results. This also includes ensuring that there are qualified providers and a comprehensive set of treatment and recovery services throughout the state.

(b) The council shall:

(1) review local, state, and federal initiatives and funding related to prevention and education, treatment, and services for individuals and families experiencing and affected by opioid abuse, and promoting innovation and capacity building to address the opioid addiction and overdose epidemic;

(2) establish priorities to address the state's opioid addiction and overdose epidemic for the purpose of allocating funds and consult with the commissioner of management and budget and the commissioner of human services to determine whether proposals are for evidence-based practices, promising practices, or theory-based practices and whether proposals align with evidence-based practices for opioid use disorder and co-occurring conditions according to the Substance Abuse and Mental Health Services Administration and the American Society for Addiction Medicine;

(3) ensure that available funding under this section is allocated to align with existing state and federal funding to achieve the greatest impact and ensure a coordinated state effort to address the opioid addiction and overdose epidemic;

(4) develop criteria and procedures to be used in awarding grants and allocating available funds from the opiate epidemic response account and select proposals to receive grant funding. The council is encouraged to select proposals that are promising practices or theory-based practices, in addition to evidence-based practices, to help identify new approaches to effective prevention, treatment, and recovery; and

(5) in consultation with the commissioner of management and budget, and within available appropriations, select from the awarded grants projects that include promising practices or theory-based activities for which the commissioner of management and budget shall conduct evaluations using experimental or quasi-experimental design. Grants awarded to proposals that include promising practices or theory-based activities and that are selected for an evaluation shall be administered to support the experimental or quasi-experimental evaluation and require grantees to collect and report information that is needed to complete the evaluation. The commissioner of management and budget, under section 15.08, may obtain additional relevant data to support the experimental or quasi-experimental evaluation studies.

Subd. 2. **Membership.** (a) The council shall consist of 19 members appointed by the commissioner of human services, except as otherwise specified:

(1) two members of the house of representatives, one from the majority party appointed by the speaker of the house and one from the minority party appointed by the minority leader;

(2) two members of the senate, one from the majority party appointed by the senate majority leader and one from the minority party appointed by the senate minority leader;

(3) one member appointed by the Board of Pharmacy;

(4) one member who is a physician appointed by the Minnesota chapter of the American College of Emergency Physicians;

(5) one member representing opioid treatment programs or other medication-assisted treatment programs;

(6) one member who is a physician appointed by the Minnesota Hospital Association;

(7) one member who is a physician appointed by the Minnesota Society of Addiction Medicine;

(8) one member who is a pain psychologist;

(9) one member appointed by the Steve Rummler Hope Network;

(10) one member appointed by the Minnesota Ambulance Association;

(11) one member representing the Minnesota courts who is a judge or law enforcement officer;

(12) two public members who are Minnesota residents and who have been impacted by the opioid epidemic;

(13) two members representing an Indian tribe;

(14) the commissioner of human services or designee; and

(15) the commissioner of health or designee.

(b) The commissioner of human services shall coordinate appointments to provide geographic diversity and shall ensure that at least one-half of the council members appointed by the commissioner reside outside of the seven-county metropolitan area.

(c) The council is governed by section 15.059, except that members of the council who are receiving compensation for the member's appointed role shall receive no compensation other than reimbursement for expenses. Notwithstanding section 15.059, subdivision 6, the council shall not expire.

(d) The chair shall convene the council at least quarterly, and may convene other meetings as necessary. The chair shall convene meetings at different locations in the state to provide geographic access, and shall ensure that at least one-half of the meetings are held at locations outside of the seven-county metropolitan area.

(e) The commissioner of human services shall provide staff and administrative services for the advisory council.

(f) The council is subject to chapter 13D.

Subd. 3. **Conflict of interest.** Advisory council members must disclose to the council and recuse themselves from voting on any matter before the council if the member has a conflict of interest. A conflict of interest means a financial association that has the potential to bias or have the appearance of biasing a council member's decision related to the opiate epidemic response grant decision process or other council activities under this section.

Subd. 4. **Council recommendations.** The council shall make recommendations on the funds annually appropriated to the commissioner of human services from the opioid stewardship fund to be awarded for the upcoming fiscal year.

Subd. 5. **Grants.** The commissioner of human services shall award grants within appropriations from the opioid stewardship fund under section 256.043. The grants shall be awarded based on recommendations from the advisory council that address the priorities in subdivision 1, paragraph (a), clauses (1) to (3).

Subd. 6. **Reports.** (a) The commissioner, in consultation with the advisory council, shall report annually to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by March 1 of each year beginning March 1, 2022, information about the individual projects that receive grants and the overall role of the project in addressing the opioid addiction and overdose epidemic in Minnesota. The report must describe the grantees and the activities implemented, along with measurable outcomes as determined by the council in consultation with the commissioner of human services and the commissioner of management and budget. At a minimum, the report must include information about the number of individuals who received information or treatment, the outcomes the individuals achieved, and demographic information about the individuals participating in the project; an assessment of the progress toward achieving statewide access to qualified providers and comprehensive treatment and recovery services; and an update on the evaluation implemented by the commissioner of management and budget for the promising practices and theory-based projects that receive funding. Each report must also identify instances in which the commissioner did not follow

recommendations of the advisory council and the commissioner's rationale for not doing so.

(b) The commissioner of management and budget, in consultation with the Opioid Stewardship Advisory Council and the commissioner of human services, shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance when an evaluation study described in subdivision 1, paragraph (b), clause (5), is complete on the promising practices or theory-based projects that are selected for evaluation activities. The report shall include demographic information; outcome information for the individuals in the program; the results for the program in promoting recovery, employment, family reunification, and reducing involvement with the criminal justice system; and other relevant outcomes determined by the commissioner of management and budget that are specific to the projects that are evaluated. The report shall include information about the ability of grant programs to be scaled to achieve the statewide results that the grant project demonstrated.

Sec. 25. **[256.043] OPIOID STEWARDSHIP FUND.**

The opioid stewardship fund is established in the state treasury. The registration fees assessed by the Board of Pharmacy under section 151.77 and the license fees identified in section 151.065, subdivision 3a, shall be deposited into the fund. All interest earnings shall be credited to the fund.

Sec. 26. **OPIOID STEWARDSHIP ADVISORY COUNCIL FIRST MEETING.**

The commissioner of human services shall convene the first meeting of the Opioid Stewardship Advisory Council established under Minnesota Statutes, section 256.042, no later than October 1, 2019. The members shall elect a chair at the first meeting.

ARTICLE 11
HEALTH-RELATED LICENSING BOARDS

Section 1. **[144A.39] FEES.**

Subdivision 1. **Nonrefundable fees.** All fees are nonrefundable.

Subd. 2. **Amounts.** (a) Fees may not exceed the following amounts but may be adjusted lower by board direction and are for the exclusive use of the board as required to sustain board operations. The maximum amounts of fees are:

(1) application for licensure, $200;

(2) for a prospective applicant for a review of education and experience advisory to the license application, $100, to be applied to the fee for application for licensure if the latter is submitted within one year of the request for review of education and experience;

(3) state examination, $125;

(4) initial license, $250 if issued between July 1 and December 31, $100 if issued between January 1 and June 30;

(5) acting administrator permit, $400;

(6) renewal license, $250;

(7) duplicate license, $50;

(8) reinstatement fee, $250;

(9) health services executive initial license, $200;

(10) health services executive renewal license, $200;

(11) reciprocity verification fee, $50;

(12) second shared administrator assignment, $250;

(13) continuing education fees:

(i) greater than 6 hours, $50; and

(ii) 7 hours or more, $75;

(14) education review, $100;

(15) fee to a sponsor for review of individual continuing education seminars, institutes, workshops, or home study courses:

(i) for less than seven clock hours, $30; and

(ii) for seven or more clock hours, $50;

(16) fee to a licensee for review of continuing education seminars, institutes, workshops, or home study courses not previously approved for a sponsor and submitted with an application for license renewal:

(i) for less than seven clock hours total, $30; and

(ii) for seven or more clock hours total, $50;

(17) late renewal fee, $75;

(18) fee to a licensee for verification of licensure status and examination scores, $30;

(19) registration as a registered continuing education sponsor, $1,000; and

(20) mail labels, $75.

(b) The revenue generated from the fees must be deposited in an account in the state government special revenue fund.

Sec. 2. Minnesota Statutes 2018, section 147D.27, is amended by adding a subdivision to read:

Subd. 5. **Additional fees.** (a) The following fees also apply:

(1) traditional midwifery annual registration fee, $100;

(2) traditional midwifery application fee, $100;

(3) traditional midwifery late fee, $75;

(4) traditional midwifery inactive status, $50;

(5) traditional midwifery temporary permit, $75;

(6) traditional midwifery certification fee, $25;

(7) duplicate license or registration fee, $20;

(8) certification letter, $25;

(9) education or training program approval fee, $100; and

(10) report creation and generation, $60 per hour billed in quarter-hour increments with a quarter-hour minimum.

(b) The revenue generated from the fees must be deposited in an account in the state government special revenue fund.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 3. Minnesota Statutes 2018, section 147E.40, subdivision 1, is amended to read:

Subdivision 1. **Fees.** (a) Fees are as follows:

(1) registration application fee, $200;

(2) renewal fee, $150;

(3) late fee, $75;

(4) inactive status fee, $50; ~~and~~

(5) temporary permit fee, $25~~.~~;

(6) naturopathic doctor certification fee, $25;

(7) naturopathic doctor duplicate license fee, $20;

(8) naturopathic doctor emeritus registration fee, $50;

(9) naturopathic doctor certification fee, $25;

(10) duplicate license or registration fee, $20;

(11) education or training program approval fee, $100; and

(12) report creation and generation, $60 per hour billed in quarter-hour increments with a quarter-hour minimum.

(b) The revenue generated from the fees must be deposited in an account in the state government special revenue fund.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 4. Minnesota Statutes 2018, section 147F.17, subdivision 1, is amended to read:

Subdivision 1. **Fees.** (a) Fees are as follows:

(1) license application fee, $200;

(2) initial licensure and annual renewal, $150; ~~and~~

(3) late fee, $75~~.~~;

(4) genetic counselor certification fee, $25;

(5) duplicate license fee, $20;

(6) education or training program approval fee, $100; and

(7) report creation and generation, $60 per hour billed in quarter-hour increments with a quarter-hour minimum.

(b) The revenue generated from the fees must be deposited in an account in the state government special revenue fund.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 5. Minnesota Statutes 2018, section 148.59, is amended to read:

148.59 LICENSE RENEWAL; LICENSE AND REGISTRATION FEES.

A licensed optometrist shall pay to the state Board of Optometry a fee as set by the board in order to renew a license as provided by board rule. No fees shall be refunded. Fees may not exceed the following amounts but may be adjusted lower by board direction and are for the exclusive use of the board:

(1) optometry licensure application, $160;

(2) optometry annual licensure renewal, ~~$135~~ $200;

(3) optometry late penalty fee, $75;

(4) annual license renewal card, $10;

(5) continuing education provider application, $45;

(6) emeritus registration, $10;

(7) endorsement/reciprocity application, $160;

(8) replacement of initial license, $12; ~~and~~

(9) license verification, $50~~.~~;

(10) state juris prudence examination, $75; and

(11) miscellaneous labels and data retrieval, $50.

Sec. 6. Minnesota Statutes 2018, section 148.6445, subdivision 1, is amended to read:

Subdivision 1. **Initial licensure fee.** The initial licensure fee for occupational therapists is ~~$145~~ $185. The initial licensure fee for occupational therapy assistants is ~~$80~~ $105. ~~The board shall prorate fees based on the number of quarters remaining in the biennial licensure period.~~

Sec. 7. Minnesota Statutes 2018, section 148.6445, subdivision 2, is amended to read:

Subd. 2. **Licensure renewal fee.** The biennial licensure renewal fee for occupational therapists is ~~$145~~ $185. The biennial licensure renewal fee for occupational therapy assistants is ~~$80~~ $105.

Sec. 8. Minnesota Statutes 2018, section 148.6445, subdivision 2a, is amended to read:

Subd. 2a. **Duplicate license fee.** The fee for a duplicate license is ~~$25~~ $30.

Sec. 9. Minnesota Statutes 2018, section 148.6445, subdivision 3, is amended to read:

Subd. 3. **Late fee.** The fee for late submission of a renewal application is ~~$25~~ $50.

Sec. 10. Minnesota Statutes 2018, section 148.6445, subdivision 4, is amended to read:

Subd. 4. **Temporary licensure fee.** The fee for temporary licensure is ~~$50~~ $75.

Sec. 11. Minnesota Statutes 2018, section 148.6445, subdivision 5, is amended to read:

Subd. 5. **Limited licensure fee.** The fee for limited licensure is ~~$96~~ $100.

Sec. 12. Minnesota Statutes 2018, section 148.6445, subdivision 6, is amended to read:

Subd. 6. **Fee for course approval after lapse of licensure.** The fee for course approval after lapse of licensure is ~~$96~~ $100.

Sec. 13. Minnesota Statutes 2018, section 148.6445, subdivision 10, is amended to read:

Subd. 10. **Use of fees.** (a) All fees are nonrefundable. The board shall only use fees collected under this section for the purposes of administering this chapter. The legislature must not transfer money generated by these fees from the state government special revenue fund to the general fund.

(b) Licensure fees are for the exclusive use of the board and shall be established by the board not to exceed the nonrefundable amounts in this section.

Sec. 14. Minnesota Statutes 2018, section 148.7815, subdivision 1, is amended to read:

Subdivision 1. **Fees.** (a) The board shall establish fees as follows:

(1) application fee, $50; ~~and~~

(2) annual license fee, $100~~.~~;

(3) athletic trainer certification fee, $25;

(4) athletic trainer duplicate license fee, $20;

(5) naturopathic doctor certification fee, $25;

(6) duplicate license or registration fee, $20;

(7) education or training program approval fee, $100;

(8) report creation and generation, $60 per hour billed in quarter-hour increments with a quarter-hour minimum; and

(9) examination administrative fee:

(i) half day, $50; and

(ii) full day, $80.

(b) The revenue generated from the fees must be deposited in an account in the state government special revenue fund.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 15. **[148.981] FEES.**

Subdivision 1. **Licensing fees.** The nonrefundable fees for licensure shall be established by the board, not to exceed the following amounts:

(1) application for admission to national standardized examination, $150;

(2) application for professional responsibility examination, $150;

(3) application for licensure as a licensed psychologist, $500;

(4) renewal of license for a licensed psychologist, $500;

(5) late renewal of license for a licensed psychologist, $250;

(6) application for converting from master's to doctoral level licensure, $150;

(7) application for guest licensure, $150;

(8) certificate replacement fee, $25;

(9) mailing and duplication fee, $5;

(10) statute and rule book fee, $10;

(11) verification fee, $20; and

(12) fee for optional preapproval of postdoctoral supervision, $50.

Subd. 2. **Continuing education sponsor fee.** A sponsor applying for approval of a continuing education activity pursuant to Minnesota Rules, part 7200.3830, subpart 2, shall submit with the application a fee to be established by the board, not to exceed $80 for each activity.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 16. Minnesota Statutes 2018, section 148E.180, is amended to read:

148E.180 FEE AMOUNTS.

Subdivision 1. **Application fees.** Nonrefundable application fees for licensure ~~are as follows~~ may not exceed the following amounts but may be adjusted lower by board action:

(1) for a licensed social worker, ~~$45~~ $75;

(2) for a licensed graduate social worker, ~~$45~~ $75;

(3) for a licensed independent social worker, ~~$45~~ $75;

(4) for a licensed independent clinical social worker, ~~$45~~ $75;

(5) for a temporary license, $50; and

(6) for a ~~licensure~~ license by endorsement, ~~$85~~ $115.

The fee for criminal background checks is the fee charged by the Bureau of Criminal Apprehension. The criminal background check fee must be included with the application fee as required according to section 148E.055.

Subd. 2. **License fees.** Nonrefundable license fees ~~are as follows~~ may not exceed the following amounts but may be adjusted lower by board action:

(1) for a licensed social worker, ~~$81~~ $115;

(2) for a licensed graduate social worker, ~~$144~~ $210;

(3) for a licensed independent social worker, ~~$216~~ $305;

(4) for a licensed independent clinical social worker, ~~$238.50~~ $335;

(5) for an emeritus inactive license, ~~$43.20~~ $65;

(6) for an emeritus active license, one-half of the renewal fee specified in subdivision 3; and

(7) for a temporary leave fee, the same as the renewal fee specified in subdivision 3.

If the licensee's initial license term is less or more than 24 months, the required license fees must be prorated proportionately.

Subd. 3. **Renewal fees.** Nonrefundable renewal fees for licensure ~~are as follows~~ may not exceed the following amounts but may be adjusted lower by board action:

(1) for a licensed social worker, ~~$81~~ $115;

(2) for a licensed graduate social worker, ~~$144~~ $210;

(3) for a licensed independent social worker, ~~$216~~ $305; and

(4) for a licensed independent clinical social worker, ~~$238.50~~ $335.

Subd. 4. **Continuing education provider fees.** Continuing education provider fees are ~~as follows~~ the following nonrefundable amounts:

(1) for a provider who offers programs totaling one to eight clock hours in a one-year period according to section 148E.145, $50;

(2) for a provider who offers programs totaling nine to 16 clock hours in a one-year period according to section 148E.145, $100;

(3) for a provider who offers programs totaling 17 to 32 clock hours in a one-year period according to section 148E.145, $200;

(4) for a provider who offers programs totaling 33 to 48 clock hours in a one-year period according to section 148E.145, $400; and

(5) for a provider who offers programs totaling 49 or more clock hours in a one-year period according to section 148E.145, $600.

Subd. 5. **Late fees.** Late fees are ~~as follows~~ the following nonrefundable amounts:

(1) renewal late fee, one-fourth of the renewal fee specified in subdivision 3;

(2) supervision plan late fee, $40; and

(3) license late fee, $100 plus the prorated share of the license fee specified in subdivision 2 for the number of months during which the individual practiced social work without a license.

Subd. 6. **License cards and wall certificates.** (a) The nonrefundable fee for a license card as specified in section 148E.095 is $10.

(b) The nonrefundable fee for a license wall certificate as specified in section 148E.095 is $30.

Subd. 7. **Reactivation fees.** Reactivation fees are ~~as follows~~ the following nonrefundable amounts:

(1) reactivation from a temporary leave or emeritus status, the prorated share of the renewal fee specified in subdivision 3; and

(2) reactivation of an expired license, 1-1/2 times the renewal fees specified in subdivision 3.

Sec. 17. Minnesota Statutes 2018, section 150A.06, is amended by adding a subdivision to read:

Subd. 10. **Emeritus inactive license.** A person licensed to practice dentistry, dental therapy, dental hygiene, or dental assisting pursuant to section 150A.05 or Minnesota Rules, part 3100.8500, who retires from active practice in the state may apply to the board for emeritus inactive licensure. An application for emeritus inactive licensure may be made on the biennial licensing form or by petitioning the board, and the applicant must pay a onetime application fee pursuant to section 150A.091, subdivision 19. In order to receive emeritus inactive licensure, the applicant must be in compliance with board requirements and cannot be the subject of current disciplinary action resulting in suspension, revocation, disqualification, condition, or restriction of the licensee to practice dentistry, dental therapy, dental hygiene, or dental assisting. An emeritus inactive license is not a license to practice, but is a formal recognition of completion of a person's dental career in good standing.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 18. Minnesota Statutes 2018, section 150A.06, is amended by adding a subdivision to read:

Subd. 11. **Emeritus active licensure.** (a) A person licensed to practice dentistry, dental therapy, dental hygiene, or dental assisting may apply for an emeritus active license if the person is retired from active practice, is in compliance with board requirements, and is not the subject of current disciplinary action resulting in suspension, revocation, disqualification, condition, or restriction of the license to practice dentistry, dental therapy, dental hygiene, or dental assisting.

(b) An emeritus active licensee may engage only in the following types of practice:

(1) pro bono or volunteer dental practice;

(2) paid practice not to exceed 500 hours per calendar year for the exclusive purpose of providing licensing supervision to meet the board's requirements; or

(3) paid consulting services not to exceed 500 hours per calendar year.

(c) An emeritus active licensee shall not hold out as a full licensee and may only hold out as authorized to practice as described in this subdivision. The board may take disciplinary or corrective action against an emeritus active licensee based on violations of applicable law or board requirements.

(d) A person may apply for an emeritus active license by completing an application form specified by the board and must pay the application fee pursuant to section 150A.091, subdivision 20.

(e) If an emeritus active license is not renewed every two years, the license expires. The renewal date is the same as the licensee's renewal date when the licensee was in active practice. In order to renew an emeritus active license, the licensee must:

(1) complete an application form as specified by the board;

(2) pay the required renewal fee pursuant to section 150A.091, subdivision 20; and

(3) report at least 25 continuing education hours completed since the last renewal, which must include:

(i) at least one hour in two different required CORE areas;

(ii) at least one hour of mandatory infection control;

(iii) for dentists and dental therapists, at least 15 hours of fundamental credits for dentists and dental therapists, and for dental hygienists and dental assistants, at least seven hours of fundamental credits; and

(iv) for dentists and dental therapists, no more than ten elective credits, and for dental hygienists and dental assistants, no more than six elective credits.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 19. Minnesota Statutes 2018, section 150A.091, is amended by adding a subdivision to read:

Subd. 19. **Emeritus inactive license.** An individual applying for emeritus inactive licensure under section 150A.06, subdivision 10, must pay a onetime fee of $50. There is no renewal fee for an emeritus inactive license.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 20. Minnesota Statutes 2018, section 150A.091, is amended by adding a subdivision to read:

Subd. 20. **Emeritus active license.** An individual applying for emeritus active licensure under section 150A.06, subdivision 11, must pay a fee upon application and upon renewal every two years. The fees for emeritus active license application and renewal are as follows: dentist, $212; dental therapist, $100; dental hygienist, $75; and dental assistant, $55.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 21. Minnesota Statutes 2018, section 151.065, subdivision 1, is amended to read:

Subdivision 1. **Application fees.** Application fees for licensure and registration are as follows:

(1) pharmacist licensed by examination, ~~$145~~ $175;

(2) pharmacist licensed by reciprocity, ~~$240~~ $275;

(3) pharmacy intern, ~~$37.50~~ $50;

(4) pharmacy technician, ~~$37.50~~ $50;

(5) pharmacy, ~~$225~~ $260;

(6) drug wholesaler, legend drugs only, ~~$235~~ $260;

(7) drug wholesaler, legend and nonlegend drugs, ~~$235~~ $260;

(8) drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, ~~$210~~ $260;

(9) drug wholesaler, medical gases, ~~$175~~ $260;

(10) drug wholesaler, also licensed as a pharmacy in Minnesota, ~~$150~~ $260;

(11) drug manufacturer, legend drugs only, ~~$235~~ $260;

(12) drug manufacturer, legend and nonlegend drugs, ~~$235~~ $260;

(13) drug manufacturer, nonlegend or veterinary legend drugs, ~~$210~~ $260;

(14) drug manufacturer, medical gases, ~~$185~~ $260;

(15) drug manufacturer, also licensed as a pharmacy in Minnesota, ~~$150~~ $260;

(16) medical gas distributor, ~~$110~~ $260; and

~~(17) controlled substance researcher, $75; and~~

~~(18)~~ (17) pharmacy professional corporation, ~~$125~~ $150.

Sec. 22. Minnesota Statutes 2018, section 151.065, subdivision 2, is amended to read:

Subd. 2. **Original license fee.** The pharmacist original licensure fee, ~~$145~~ $175.

Sec. 23. Minnesota Statutes 2018, section 151.065, subdivision 3, is amended to read:

Subd. 3. **Annual renewal fees.** Annual licensure and registration renewal fees are as follows:

(1) pharmacist, ~~$145~~ $175;

(2) pharmacy technician, ~~$37.50~~ $50;

(3) pharmacy, ~~$225~~ $260;

(4) drug wholesaler, legend drugs only, ~~$235~~ $260;

(5) drug wholesaler, legend and nonlegend drugs, ~~$235~~ $260;

(6) drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, ~~$210~~ $260;

(7) drug wholesaler, medical gases, ~~$185~~ $260;

(8) drug wholesaler, also licensed as a pharmacy in Minnesota, ~~$150~~ $260;

(9) drug manufacturer, legend drugs only, ~~$235~~ $260;

(10) drug manufacturer, legend and nonlegend drugs, ~~$235~~ $260;

(11) drug manufacturer, nonlegend, veterinary legend drugs, or both, ~~$210~~ $260;

(12) drug manufacturer, medical gases, ~~$185~~ $260;

(13) drug manufacturer, also licensed as a pharmacy in Minnesota, ~~$150~~ $260;

(14) medical gas distributor, ~~$110~~ $260; and

~~(15) controlled substance researcher, $75; and~~

~~(16)~~ (15) pharmacy professional corporation, ~~$75~~ $100.

Sec. 24. Minnesota Statutes 2018, section 151.065, subdivision 6, is amended to read:

Subd. 6. **Reinstatement fees.** (a) A pharmacist who has allowed the pharmacist's license to lapse may reinstate the license with board approval and upon payment of any fees and late fees in arrears, up to a maximum of $1,000.

(b) A pharmacy technician who has allowed the technician's registration to lapse may reinstate the registration with board approval and upon payment of any fees and late fees in arrears, up to a maximum of $90.

(c) An owner of a pharmacy, a drug wholesaler, a drug manufacturer, or a medical gas distributor who has allowed the license of the establishment to lapse may reinstate the license with board approval and upon payment of any fees and late fees in arrears.

(d) A controlled substance ~~researcher~~ registrant who has allowed ~~the researcher's~~ a registration issued pursuant to subdivision 4 to lapse may reinstate the registration with board approval and upon payment of any fees and late fees in arrears.

(e) A pharmacist owner of a professional corporation who has allowed the corporation's registration to lapse may reinstate the registration with board approval and upon payment of any fees and late fees in arrears.

Sec. 25. **REPEALER.**

Minnesota Rules, parts 6400.6970; 7200.6100; and 7200.6105, are repealed.

EFFECTIVE DATE. This section is effective the day following final enactment.

ARTICLE 12
HEALTH DEPARTMENT

Section 1. Minnesota Statutes 2018, section 144.3831, subdivision 1, is amended to read:

Subdivision 1. **Fee setting.** The commissioner of health may assess an annual fee of ~~$6.36~~ $9.72 for every service connection to a public water supply that is owned or operated by a home rule charter city, a statutory city, a city of the first class, or a town. The commissioner of health may also assess an annual fee for every service connection served by a water user district defined in section 110A.02.

EFFECTIVE DATE. This section is effective January 1, 2020.

Sec. 2. **[144.397] STATEWIDE TOBACCO CESSATION SERVICES.**

(a) The commissioner of health shall administer, or contract for the administration of, statewide tobacco cessation services to assist Minnesotans who are seeking advice or services to help them quit using tobacco products. The commissioner shall establish statewide public awareness activities to inform the public of the availability of the services and encourage the public to utilize the services because of the dangers and harm of tobacco use and dependence.

(b) Services to be provided may include but are not limited to:

(1) telephone-based coaching and counseling;

(2) referrals;

(3) written materials mailed upon request;

(4) web-based texting or e-mail services; and

(5) free Food and Drug Administration-approved tobacco cessation medications.

(c) Services provided must be consistent with evidence-based best practices in tobacco cessation services. Services provided must be coordinated with health plan company tobacco prevention and cessation services that may be available to individuals depending on their health coverage.

Sec. 3. **[145.9275] COMMUNITY-BASED OPIOID AND OTHER DRUG ABUSE PREVENTION; PILOT GRANT PROGRAM.**

Subdivision 1. **Community pilot prevention projects.** To the extent funds are appropriated for the purposes of this subdivision, the commissioner shall establish a grant program to fund community opioid abuse prevention pilot grants to reduce emergency room and other health care provider visits resulting from opioid use or abuse and to reduce rates of opioid addiction in the community using the following six activities:

(1) establishing multidisciplinary controlled substance care teams that may consist of physicians, pharmacists, social workers, nurse care coordinators, and mental health professionals;

(2) delivering health care services and care coordination, through controlled substance care teams, to reduce the inappropriate use of opioids by patients and rates of opioid addiction;

(3) addressing any unmet social services needs that create barriers to managing pain effectively and obtaining optimal health outcomes;

(4) providing prescriber and dispenser education and assistance to reduce the inappropriate prescribing and dispensing of opioids;

(5) promoting the adoption of best practices related to opioid disposal and reducing opportunities for illegal access to opioids; and

(6) engaging partners outside of the health care system, including schools, law enforcement, and social services, to address root causes of opioid abuse and addiction at the community level.

Subd. 2. **Culture as health; preventing disparities.** To the extent funds are appropriated for the purposes of this subdivision, the commissioner shall establish a grant program to fund organizations working directly with African Americans, urban American Indians, and Minnesota's 11 Tribal Nations. For grants to Tribal Nations, the tribal governments shall determine how to best use allocated funds to address and prevent substance use disorder and overdoses within their communities.

Sec. 4. **[145.9285] COMMUNITY SOLUTIONS FOR HEALTHY CHILD DEVELOPMENT GRANT PROGRAM.**

Subdivision 1. **Establishment.** The commissioner shall establish the community solutions for healthy child development grant program. The purpose of the program is to:

(1) improve child development outcomes as related to the well-being of children of color and American Indian children from prenatal to grade 3 and their families, including but not limited to the goals outlined by the Department of Human Service's early childhood systems reform effort: early learning; health and well-being; economic security; and safe, stable, nurturing relationships and environments by funding community-based solutions for challenges that are identified by the affected community;

(2) reduce racial disparities in children's health and development, from prenatal to grade 3; and

(3) promote racial and geographic equity.

Subd. 2. **Commissioner's duties.** The commissioner of health shall:

(1) develop a request for proposals for the healthy child development grant program in consultation with the Community Solutions Advisory Council;

(2) provide outreach, technical assistance, and program development support to increase capacity for new and existing service providers in order to better meet statewide needs, particularly in greater Minnesota and areas where services to reduce health disparities have not been established;

(3) review responses to requests for proposals, in consultation with the Community Solutions Advisory Council, and award grants under this section;

(4) ensure communication with the ethnic councils, Minnesota Indian Affairs Council, and the governor's early learning council on the request for proposal process;

(5) establish a transparent and objective accountability process, in consultation with the Community Solutions Advisory Council, focused on outcomes that grantees agree to achieve;

(6) provide grantees with access to data to assist grantees in establishing and implementing effective community-led solutions;

(7) maintain data on outcomes reported by grantees; and

(8) contract with an independent third-party entity to evaluate the success of the grant program and to build the evidence base for effective community solutions in reducing health disparities of children of color and American Indian children from prenatal to grade 3.

Subd. 3. **Community Solutions Advisory Council; establishment; duties; compensation.** (a) No later than October 1, 2019, the commissioner shall convene a 12-member Community Solutions Advisory Council as follows:

(1) two members representing the African Heritage community;

(2) two members representing the Latino community;

(3) two members representing the Asian-Pacific Islander community;

(4) two members representing the American Indian community;

(5) two parents of children of color or that are American Indian with children under nine years of age;

(6) one member with research or academic expertise in racial equity and healthy child development; and

(7) one member representing an organization that advocates on behalf of communities of color or American Indians.

(b) At least three of the 12 members of the advisory council must come from outside the seven-county metropolitan area.

(c) The Community Solutions Advisory Council shall:

(1) advise the commissioner on the development of the request for proposals for community solutions healthy child development grants. In advising the commissioner, the council must consider how to build on the capacity of communities to promote child and family well-being and address social determinants of healthy child development;

(2) review responses to requests for proposals and advise the commissioner on the selection of grantees and grant awards;

(3) advise the commissioner on the establishment of a transparent and objective accountability process focused on outcomes the grantees agree to achieve;

(4) advise the commissioner on ongoing oversight and necessary support in the implementation of the program; and

(5) support the commissioner on other racial equity and early childhood grant efforts.

(d) Each advisory council member shall be compensated in accordance with section 15.059, subdivision 3.

Subd. 4. **Eligible grantees.** Organizations eligible to receive grant funding under this section include:

(1) organizations or entities that work with communities of color and American Indian communities;

(2) tribal nations and tribal organizations as defined in section 658P of the Child Care and Development Block Grant Act of 1990; and

(3) organizations or entities focused on supporting healthy child development.

Subd. 5. **Strategic consideration and priority of proposals; eligible populations; grant awards.** (a) The commissioner, in consultation with the Community Solutions Advisory Council, shall develop a request for proposals for healthy child development grants. In developing the proposals and awarding the grants, the commissioner shall consider building on the capacity of communities to promote child and family well-being and address social determinants of healthy child development. Proposals must focus on increasing racial equity and healthy child development and reducing health disparities experienced by children of color and American Indian children from prenatal to grade 3 and their families.

(b) In awarding the grants, the commissioner shall provide strategic consideration and give priority to proposals from:

(1) organizations or entities led by people of color and serving communities of color;

(2) organizations or entities led by American Indians and serving American Indians, including tribal nations and tribal organizations;

(3) organizations or entities with proposals focused on healthy development from prenatal to age three;

(4) organizations or entities with proposals focusing on multigenerational solutions;

(5) organizations or entities located in or with proposals to serve communities located in counties that are moderate to high risk according to the Wilder Research Risk and Reach Report; and

(6) community-based organizations that have historically served communities of color and American Indians and have not traditionally had access to state grant funding.

The advisory council may recommend additional strategic considerations and priorities to the commissioner.

(c) The first round of grants must be awarded no later than April 15, 2020. Grants must be awarded annually thereafter. Grants are awarded for a period of three years.

Subd. 6. **Geographic distribution of grants.** The commissioner and the advisory council shall ensure that grant funds are prioritized and awarded to organizations and entities that

are within counties that have a higher proportion of people of color and American Indians than the state average, to the extent possible.

Subd. 7. **Report.** Grantees must report grant program outcomes to the commissioner on the forms and according to the timelines established by the commissioner.

Sec. 5. Minnesota Statutes 2018, section 152.22, subdivision 13, is amended to read:

Subd. 13. **Registry verification.** "Registry verification" means the verification provided by the commissioner that a patient is enrolled in the registry program and that includes the patient's name, registry number, and qualifying medical condition and, if applicable, the name of the patient's registered designated caregiver or parent ~~or~~, legal guardian, or spouse.

Sec. 6. Minnesota Statutes 2018, section 152.25, subdivision 1c, is amended to read:

Subd. 1c. **Notice to patients.** Upon the revocation or nonrenewal of a manufacturer's registration under subdivision 1a or implementation of an enforcement action under subdivision 1b that may affect the ability of a registered patient, registered designated caregiver, or a registered patient's parent ~~or~~, legal guardian, or spouse to obtain medical cannabis from the manufacturer subject to the enforcement action, the commissioner shall notify in writing each registered patient and the patient's registered designated caregiver or registered patient's parent ~~or~~, legal guardian, or spouse about the outcome of the proceeding and information regarding alternative registered manufacturers. This notice must be provided two or more business days prior to the effective date of the revocation, nonrenewal, or other enforcement action.

Sec. 7. Minnesota Statutes 2018, section 152.27, subdivision 3, is amended to read:

Subd. 3. **Patient application.** (a) The commissioner shall develop a patient application for enrollment into the registry program. The application shall be available to the patient and given to health care practitioners in the state who are eligible to serve as health care practitioners. The application must include:

(1) the name, mailing address, and date of birth of the patient;

(2) the name, mailing address, and telephone number of the patient's health care practitioner;

(3) the name, mailing address, and date of birth of the patient's designated caregiver, if any, or the patient's parent ~~or~~, legal guardian, or spouse if the parent ~~or~~, legal guardian, or spouse will be acting as a caregiver;

(4) a copy of the certification from the patient's health care practitioner that is dated within 90 days prior to submitting the application which certifies that the patient has been diagnosed with a qualifying medical condition and, if applicable, that, in the health care practitioner's medical opinion, the patient is developmentally or physically disabled and, as a result of that disability, the patient is unable to self-administer medication or acquire medical cannabis from a distribution facility; and

(5) all other signed affidavits and enrollment forms required by the commissioner under sections 152.22 to 152.37, including, but not limited to, the disclosure form required under paragraph (c).

(b) The commissioner shall require a patient to resubmit a copy of the certification from the patient's health care practitioner on a yearly basis and shall require that the recertification be dated within 90 days of submission.

(c) The commissioner shall develop a disclosure form and require, as a condition of enrollment, all patients to sign a copy of the disclosure. The disclosure must include:

(1) a statement that, notwithstanding any law to the contrary, the commissioner, or an employee of any state agency, may not be held civilly or criminally liable for any injury, loss of property, personal injury, or death caused by any act or omission while acting within the scope of office or employment under sections 152.22 to 152.37; and

(2) the patient's ~~acknowledgement~~ acknowledgment that enrollment in the patient registry program is conditional on the patient's agreement to meet all of the requirements of sections 152.22 to 152.37.

Sec. 8. Minnesota Statutes 2018, section 152.27, subdivision 4, is amended to read:

Subd. 4. **Registered designated caregiver.** (a) The commissioner shall register a designated caregiver for a patient if the patient's health care practitioner has certified that the patient, in the health care practitioner's medical opinion, is developmentally or physically disabled and, as a result of that disability, the patient is unable to self-administer medication or acquire medical cannabis from a distribution facility and the caregiver has agreed, in writing, to be the patient's designated caregiver. As a condition of registration as a designated caregiver, the commissioner shall require the person to:

(1) be at least 21 years of age;

(2) agree to only possess any medical cannabis for purposes of assisting the patient; and

(3) agree that if the application is approved, the person will not be a registered designated caregiver for more than one patient, unless the patients reside in the same residence.

(b) The commissioner shall conduct a criminal background check on the designated caregiver prior to registration to ensure that the person does not have a conviction for a disqualifying felony offense. Any cost of the background check shall be paid by the person seeking registration as a designated caregiver. A designated caregiver must have the criminal background check renewed every two years.

Sec. 9. Minnesota Statutes 2018, section 152.27, subdivision 5, is amended to read:

Subd. 5. **Parents ~~or~~, legal guardians, and spouses.** A parent ~~or~~, legal guardian, or spouse of a patient may act as the caregiver to the patient without having to register as a designated caregiver. The parent ~~or~~, legal guardian, or spouse shall follow all of the requirements of parents ~~and~~, legal guardians, and spouses listed in sections 152.22 to 152.37. Nothing in sections 152.22 to 152.37 limits any legal authority a parent ~~or~~, legal guardian, or spouse may have for the patient under any other law.

Sec. 10. Minnesota Statutes 2018, section 152.27, subdivision 6, is amended to read:

Subd. 6. **Patient enrollment.** (a) After receipt of a patient's application, application fees, and signed disclosure, the commissioner shall enroll the patient in the registry program and issue the patient and patient's registered designated caregiver or parent ~~or~~, legal guardian, or spouse, if applicable, a registry verification. The commissioner shall approve or deny a patient's application for participation in the registry program within 30 days after the commissioner receives the patient's application and application fee. The commissioner may approve applications up to 60 days after the receipt of a patient's application and application fees until January 1, 2016. A patient's enrollment in the registry program shall only be denied if the patient:

(1) does not have certification from a health care practitioner that the patient has been diagnosed with a qualifying medical condition;

(2) has not signed and returned the disclosure form required under subdivision 3, paragraph (c), to the commissioner;

(3) does not provide the information required;

(4) has previously been removed from the registry program for violations of section 152.30 or 152.33; or

(5) provides false information.

(b) The commissioner shall give written notice to a patient of the reason for denying enrollment in the registry program.

(c) Denial of enrollment into the registry program is considered a final decision of the commissioner and is subject to judicial review under the Administrative Procedure Act pursuant to chapter 14.

(d) A patient's enrollment in the registry program may only be revoked upon the death of the patient or if a patient violates a requirement under section 152.30 or 152.33.

(e) The commissioner shall develop a registry verification to provide to the patient, the health care practitioner identified in the patient's application, and to the manufacturer. The registry verification shall include:

(1) the patient's name and date of birth;

(2) the patient registry number assigned to the patient;

(3) the patient's qualifying medical condition as provided by the patient's health care practitioner in the certification; and

(4) the name and date of birth of the patient's registered designated caregiver, if any, or the name of the patient's parent ~~or~~, legal guardian, or spouse if the parent ~~or~~, legal guardian, or spouse will be acting as a caregiver.

Sec. 11. Minnesota Statutes 2018, section 152.28, subdivision 1, is amended to read:

Subdivision 1. **Health care practitioner duties.** (a) Prior to a patient's enrollment in the registry program, a health care practitioner shall:

(1) determine, in the health care practitioner's medical judgment, whether a patient suffers from a qualifying medical condition, and, if so determined, provide the patient with a certification of that diagnosis;

(2) determine whether a patient is developmentally or physically disabled and, as a result of that disability, the patient is unable to self-administer medication or acquire medical cannabis from a distribution facility, and, if so determined, include that determination on the patient's certification of diagnosis;

(3) advise patients, registered designated caregivers, and parents ~~or~~, legal guardians, or spouses who are acting as caregivers of the existence of any nonprofit patient support groups or organizations;

(4) provide explanatory information from the commissioner to patients with qualifying medical conditions, including disclosure to all patients about the experimental nature of therapeutic use of medical cannabis; the possible risks, benefits, and side effects of the proposed treatment; the application and other materials from the commissioner; and provide patients with the Tennessen warning as required by section 13.04, subdivision 2; and

(5) agree to continue treatment of the patient's qualifying medical condition and report medical findings to the commissioner.

(b) Upon notification from the commissioner of the patient's enrollment in the registry program, the health care practitioner shall:

(1) participate in the patient registry reporting system under the guidance and supervision of the commissioner;

(2) report health records of the patient throughout the ongoing treatment of the patient to the commissioner in a manner determined by the commissioner and in accordance with subdivision 2;

(3) determine, on a yearly basis, if the patient continues to suffer from a qualifying medical condition and, if so, issue the patient a new certification of that diagnosis; and

(4) otherwise comply with all requirements developed by the commissioner.

(c) Nothing in this section requires a health care practitioner to participate in the registry program.

Sec. 12. Minnesota Statutes 2018, section 152.29, subdivision 3, is amended to read:

Subd. 3. **Manufacturer; distribution.** (a) A manufacturer shall require that employees licensed as pharmacists pursuant to chapter 151 be the only employees to give final approval for the distribution of medical cannabis to a patient.

(b) A manufacturer may dispense medical cannabis products, whether or not the products have been manufactured by the manufacturer, but is not required to dispense medical cannabis products.

(c) Prior to distribution of any medical cannabis, the manufacturer shall:

(1) verify that the manufacturer has received the registry verification from the commissioner for that individual patient;

(2) verify that the person requesting the distribution of medical cannabis is the patient, the patient's registered designated caregiver, or the patient's parent ~~or~~, legal guardian, or

spouse listed in the registry verification using the procedures described in section 152.11, subdivision 2d;

(3) assign a tracking number to any medical cannabis distributed from the manufacturer;

(4) ensure that any employee of the manufacturer licensed as a pharmacist pursuant to chapter 151 has consulted with the patient to determine the proper dosage for the individual patient after reviewing the ranges of chemical compositions of the medical cannabis and the ranges of proper dosages reported by the commissioner. For purposes of this clause, a consultation may be conducted remotely using a videoconference, so long as the employee providing the consultation is able to confirm the identity of the patient, the consultation occurs while the patient is at a distribution facility, and the consultation adheres to patient privacy requirements that apply to health care services delivered through telemedicine;

(5) properly package medical cannabis in compliance with the United States Poison Prevention Packing Act regarding child-resistant packaging and exemptions for packaging for elderly patients, and label distributed medical cannabis with a list of all active ingredients and individually identifying information, including:

(i) the patient's name and date of birth;

(ii) the name and date of birth of the patient's registered designated caregiver or, if listed on the registry verification, the name of the patient's parent ~~or~~, legal guardian, or spouse, if applicable;

(iii) the patient's registry identification number;

(iv) the chemical composition of the medical cannabis; and

(v) the dosage; and

(6) ensure that the medical cannabis distributed contains a maximum of a 30-day supply of the dosage determined for that patient.

(d) A manufacturer shall require any employee of the manufacturer who is transporting medical cannabis or medical cannabis products to a distribution facility to carry identification showing that the person is an employee of the manufacturer.

Sec. 13. Minnesota Statutes 2018, section 152.32, subdivision 2, is amended to read:

Subd. 2. **Criminal and civil protections.** (a) Subject to section 152.23, the following are not violations under this chapter:

(1) use or possession of medical cannabis or medical cannabis products by a patient enrolled in the registry program, or possession by a registered designated caregiver or the parent ~~or~~, legal guardian, or spouse of a patient if the parent ~~or~~, legal guardian, or spouse is listed on the registry verification;

(2) possession, dosage determination, or sale of medical cannabis or medical cannabis products by a medical cannabis manufacturer, employees of a manufacturer, a laboratory conducting testing on medical cannabis, or employees of the laboratory; and

(3) possession of medical cannabis or medical cannabis products by any person while carrying out the duties required under sections 152.22 to 152.37.

(b) Medical cannabis obtained and distributed pursuant to sections 152.22 to 152.37 and associated property is not subject to forfeiture under sections 609.531 to 609.5316.

(c) The commissioner, the commissioner's staff, the commissioner's agents or contractors, and any health care practitioner are not subject to any civil or disciplinary penalties by the Board of Medical Practice, the Board of Nursing, or by any business, occupational, or professional licensing board or entity, solely for the participation in the registry program under sections 152.22 to 152.37. A pharmacist licensed under chapter 151 is not subject to any civil or disciplinary penalties by the Board of Pharmacy when acting in accordance with the provisions of sections 152.22 to 152.37. Nothing in this section affects a professional licensing board from taking action in response to violations of any other section of law.

(d) Notwithstanding any law to the contrary, the commissioner, the governor of Minnesota, or an employee of any state agency may not be held civilly or criminally liable for any injury, loss of property, personal injury, or death caused by any act or omission while acting within the scope of office or employment under sections 152.22 to 152.37.

(e) Federal, state, and local law enforcement authorities are prohibited from accessing the patient registry under sections 152.22 to 152.37 except when acting pursuant to a valid search warrant.

(f) Notwithstanding any law to the contrary, neither the commissioner nor a public employee may release data or information about an individual contained in any report, document, or registry created under sections 152.22 to 152.37 or any information obtained about a patient participating in the program, except as provided in sections 152.22 to 152.37.

(g) No information contained in a report, document, or registry or obtained from a patient under sections 152.22 to 152.37 may be admitted as evidence in a criminal proceeding

unless independently obtained or in connection with a proceeding involving a violation of sections 152.22 to 152.37.

(h) Notwithstanding section 13.09, any person who violates paragraph (e) or (f) is guilty of a gross misdemeanor.

(i) An attorney may not be subject to disciplinary action by the Minnesota Supreme Court or professional responsibility board for providing legal assistance to prospective or registered manufacturers or others related to activity that is no longer subject to criminal penalties under state law pursuant to sections 152.22 to 152.37.

(j) Possession of a registry verification or application for enrollment in the program by a person entitled to possess or apply for enrollment in the registry program does not constitute probable cause or reasonable suspicion, nor shall it be used to support a search of the person or property of the person possessing or applying for the registry verification, or otherwise subject the person or property of the person to inspection by any governmental agency.

Sec. 14. Minnesota Statutes 2018, section 152.33, subdivision 1, is amended to read:

Subdivision 1. **Intentional diversion; criminal penalty.** In addition to any other applicable penalty in law, a manufacturer or an agent of a manufacturer who intentionally transfers medical cannabis to a person other than a patient, a registered designated caregiver or, if listed on the registry verification, a parent ~~or~~, legal guardian, or spouse of a patient is guilty of a felony punishable by imprisonment for not more than two years or by payment of a fine of not more than $3,000, or both. A person convicted under this subdivision may not continue to be affiliated with the manufacturer and is disqualified from further participation under sections 152.22 to 152.37.

Sec. 15. Minnesota Statutes 2018, section 152.33, subdivision 2, is amended to read:

Subd. 2. **Diversion by patient, registered designated caregiver, ~~or~~ parent, legal guardian, or patient's spouse; criminal penalty.** In addition to any other applicable penalty in law, a patient, registered designated caregiver or, if listed on the registry verification, a parent ~~or~~, legal guardian, or spouse of a patient who intentionally sells or otherwise transfers medical cannabis to a person other than a patient, designated registered caregiver or, if listed on the registry verification, a parent ~~or~~, legal guardian, or spouse of a patient is guilty of a felony punishable by imprisonment for not more than two years or by payment of a fine of not more than $3,000, or both.

Sec. 16. Minnesota Statutes 2018, section 214.25, subdivision 2, is amended to read:

Subd. 2. **Commissioner of health data.** ~~(a)~~ All data collected or maintained as part of the commissioner of health's duties under Minnesota Statutes 2018, sections 214.19, 214.23, and 214.24, shall be classified as investigative data under section 13.39, except that inactive investigative data shall be classified as private data under section 13.02, subdivision 12, or nonpublic data under section 13.02, subdivision 9, in the case of data not on individuals.

~~(b) Notwithstanding section 13.05, subdivision 9, data addressed in this subdivision shall not be disclosed except as provided in this subdivision or section 13.04; except that the commissioner may disclose to the boards under section 214.23.~~

~~(c) The commissioner may disclose data addressed under this subdivision as necessary: to identify, establish, implement, and enforce a monitoring plan; to investigate a regulated person; to alert persons who may be threatened by illness as evidenced by epidemiologic data; to control or prevent the spread of HIV, HBV, or HCV disease; or to diminish an imminent threat to the public health.~~

EFFECTIVE DATE. This section is effective on January 1, 2020, and no new cases shall be investigated under this subdivision after June 1, 2019.

Sec. 17. **REVISOR INSTRUCTION.**

The revisor of statutes shall correct any internal cross-references to sections 214.17 to 214.25 that occur as a result of the repealed language and may make changes necessary to correct punctuation, grammar, or structure of the remaining text and preserve its meaning.

Sec. 18. **REPEALER.**

Minnesota Statutes 2018, sections 214.17; 214.18; 214.19; 214.20; 214.21; 214.22; 214.23; and 214.24, are repealed on January 1, 2020, and no new cases shall be investigated under these sections after June 1, 2019.

ARTICLE 13
ADULT PROTECTION

Section 1. **[256M.42] ADULT PROTECTION GRANT ALLOCATION.**

Subdivision 1. **Formula.** (a) The commissioner shall allocate state money appropriated under this section to each county board and tribal government approved by the commissioner to assume county agency duties for adult protective services or as a lead investigative agency

under section 626.557 on an annual basis in an amount determined according to the following formula:

(1) 25 percent must be allocated on the basis of the number of reports of suspected vulnerable adult maltreatment under sections 626.557 and 626.5572, when the county or tribe is responsible as determined by the most recent data of the commissioner; and

(2) 75 percent must be allocated on the basis of the number of screened-in reports for adult protective services or vulnerable adult maltreatment investigations under sections 626.557 and 626.5572, when the county or tribe is responsible as determined by the most recent data of the commissioner.

(b) The commissioner is precluded from changing the formula under this subdivision or recommending a change to the legislature without public review and input.

Subd. 2. **Payment.** The commissioner shall make allocations under subdivision 1 to each county board or tribal government each year on or before July 10.

Subd. 3. **Prohibition on supplanting existing money.** Money received under this section must be used for staffing for protection of vulnerable adults or to expand adult protective services. Money must not be used to supplant current county or tribe expenditures for these purposes.

EFFECTIVE DATE. This section is effective July 1, 2020.

ARTICLE 14
ASSISTED LIVING LICENSURE

Section 1. **[144I.01] DEFINITIONS.**

Subdivision 1. **Applicability.** For the purposes of this chapter, the definitions in this section have the meanings given.

Subd. 2. **Activities of daily living.** "Activities of daily living" has the meaning given in section 256B.0659, subdivision 1, paragraph (b).

Subd. 3. **Adult.** "Adult" means a natural person who has attained the age of 18 years.

Subd. 4. **Assisted living.** "Assisted living" means a licensed establishment that: (1) provides sleeping accommodations to one or more adults; and (2) provides home care services. For purposes of this chapter, assisted living does not include:

(i) emergency shelter, transitional housing, or any other residential units serving exclusively or primarily homeless individuals, as defined under section 116L.361;

(ii) a housing with services establishment registered under section 144D.025;

(iii) a nursing home licensed under chapter 144A;

(iv) a hospital, certified boarding care, or supervised living facility licensed under sections 144.50 to 144.56;

(v) a lodging establishment licensed under chapter 157 and Minnesota Rules, parts 9520.0500 to 9520.0670, or under chapter 245D or 245G, except lodging establishments that provide dementia care services;

(vi) a lodging establishment serving as a shelter for individuals fleeing domestic violence;

(vii) services and residential settings licensed under chapter 245A, including adult foster care and services and settings governed under the standards in chapter 245D;

(viii) private homes where the residents own or rent the home and control all aspects of the property and building;

(ix) a duly organized condominium, cooperative, and common interest community, or owners' association of the condominium, cooperative, and common interest community where at least 80 percent of the units that comprise the condominium, cooperative, or common interest community are occupied by individuals who are the owners, members, or shareholders of the units;

(x) temporary family health care dwellings as defined in sections 394.307 and 462.3593;

(xi) settings offering services conducted by and for the adherents of any recognized church or religious denomination for its members through spiritual means or by prayer for healing; or

(xii) housing financed pursuant to sections 462A.37 to 462A.375, units financed with low-income housing tax credits pursuant to United States Code, title 26, section 42, and units financed by the Minnesota Housing Finance Agency that are intended to serve individuals with disabilities or individuals who are homeless.

Subd. 5. **Assisted living resident or resident.** "Assisted living resident" or "resident" means a person who resides in a licensed assisted living that is subject to the requirements of this chapter.

Subd. 6. **Commissioner.** "Commissioner" means the commissioner of health.

Subd. 7. **Controlling person.** (a) "Controlling person" means any public body, governmental agency, business entity, officer, nursing home administrator, assisted living administrator, or director whose responsibilities include the direction of the management

or policies of an assisted living. Controlling person also means any person who, directly or indirectly, beneficially owns any interest in:

(1) any corporation, partnership, limited liability company, real estate investment trust (REIT), or other business association that is a controlling person;

(2) the land on which the assisted living is located;

(3) the structure in which an assisted living is located;

(4) any mortgage, contract for deed, or other obligation secured in whole or in part by the land or structure comprising the assisted living; or

(5) any lease or sublease of the land, structure, or facilities comprising the assisted living.

(b) For purposes of this chapter, controlling person does not include:

(1) a bank, savings bank, trust company, savings association, credit union, industrial loan and thrift company, investment banking firm, or insurance company unless the entity directly or through a subsidiary operates a nursing home;

(2) an individual state official or employee, or a member or employee of the governing body of a political subdivision of the state that operates one or more assisted livings, unless the individual is also an officer or director of a nursing home, receives any remuneration from an assisted living, or owns any of the beneficial interests not excluded in this subdivision;

(3) a natural person who is a member of a tax-exempt organization under section 290.05, subdivision 2, unless the individual is also an officer or director of an assisted living, or owns any of the beneficial interests not excluded in this subdivision; and

(4) a natural person who owns less than five percent of the outstanding common shares of a corporation:

(i) whose securities are exempt by virtue of section 80A.45, clause (6); or

(ii) whose transactions are exempt by virtue of section 80A.46, clause (7).

Subd. 8. **Home care services.** "Home care services" means services as defined in section 144A.43, subdivision 3, and comprehensive PLUS services as defined in section 144I.02.

Subd. 9. **Licensee.** "Licensee" means a person or entity to whom the commissioner issues an assisted living license and is a controlling person.

Subd. 10. **Management agreement.** "Management agreement" means a written, executed agreement between a licensee and manager regarding the provision of certain services on behalf of the licensee.

Subd. 11. **Manager or operator.** "Manager" or "operator" means an entity or person possessing the right to exercise operational or management control over, or directly or indirectly conduct, the day-to-day operation of an establishment.

Subd. 12. **New construction.** "New construction" means a new building, renovation, modification, reconstruction, physical changes altering the use of occupancy, or an addition to a building.

Subd. 13. **Person-centered planning and service delivery.** "Person-centered planning and service delivery" means services as defined in section 245D.07, subdivision 1a, paragraph (b).

Subd. 14. **Supportive services.** "Supportive services" means services that may be offered or provided by an assisted living provider as part of the assisted living license and means help with personal laundry, handling or assisting with personal funds of residents, or arranging for medical services, health-related services, social services, housekeeping, central dining, recreation, or transportation. Arranging for services does not include making referrals, or contacting a service provider in an emergency.

Sec. 2. **[144I.02] ASSISTED LIVING LICENSE; APPLICABLE LAWS; APPLICATION AND RENEWAL.**

Subdivision 1. **License required.** (a) Beginning July 1, 2021, no newly formed entity may open, operate, maintain, advertise, or hold itself out as an assisted living in Minnesota unless it is licensed under this chapter.

(b) Entities that operated as a housing with services establishment under chapter 144D with an arranged home care provider licensed under section 144A.471, must convert to the assisted living license beginning July 1, 2021, in compliance with the commissioner's process so that all assisted living settings are licensed by July 1, 2022.

(c) After July 1, 2022, it shall be a criminal gross misdemeanor to open, operate, maintain, advertise, or hold oneself out as an assisted living without a license pursuant to section 609.0341, subdivision 1.

(d) No person or business shall provide both housing combined with health services without first obtaining an assisted living license from the commissioner.

Subd. 2. **Licensure levels.** (a) The levels in this subdivision are established for assisted living licensure:

(b) Basic License - For assisted living facilities that provide basic home care services as defined in section 144A.471, subdivision 6. In addition to the services defined in section 144A.471, basic license includes:

(1) assistance with activities of daily living such as bathing, dressing, grooming, eating, transfers, mobility, positioning, and toileting; and assistance with instrumental activities of daily living such as meal planning and preparation, paying bills, shopping, performing household tasks, and communication by telephone or other media; and

(2) assisting with self-administered medications.

(c) Comprehensive License - For assisted living facilities that provide services as defined in section 144A.471, subdivision 7.

(d) Comprehensive PLUS License - For assisted living facilities that provide both comprehensive home care services and services in a secure or separate dementia care unit or wing and complies with requirements in sections 144I.13 to 144I.18.

Subd. 3. **Licensed home care provider requirements applicable to assisted living licensing.** The following sections apply to assisted living licensees in this chapter:

(1) section 144A.43, subdivisions 1d, 1e, 2a to 2e, 3, 3a, 7, 10 to 16, 18 to 25, 27 to 33, 35 to 38;

(2) section 144A.44, Home Care Bill of Rights, and section 144A.441, assisted living bill of rights addendum;

(3) section 144A.45, subdivision 6, relating to tuberculosis prevention and control;

(4) section 144A.474, subdivisions 4 to 8, 11, and 12, relating to surveys, fines, and reconsiderations;

(5) section 144A.475, relating to enforcement;

(6) section 144A.476, relating to background studies;

(7) section 144A.477, relating to medicare certified home health agencies;

(8) section 144A.478, relating to innovation variance;

(9) section 144A.479, relating to quality management, handling resident's finances and property, reporting maltreatment, and employee records;

(10) section 144A.4791, relating to providers' responsibilities to clients;

(11) section 144A.4792, relating to medication management;

(12) section 144A.4793, relating to treatment and therapy management services;

(13) section 144A.4794, relating to client record requirements;

(14) section 144A.4795, relating to home care provider responsibilities regarding their staff;

(15) section 144A.4796, relating to orientation and annual training requirements;

(16) section 144A.4797, relating to provision of services;

(17) section 144A.4798, relating to employee health status;

(18) section 144A.4799, relating to Department of Health licensed home care provider advisory council;

(19) section 144A.484, relating to integrated licensure and home and community-based services designation;

(20) sections 144D.065, 144D.066, and 144D.10, relating to dementia care training, manager training, and commissioner enforcement;

(21) section 144D.07, relating to prohibition of restraints;

(22) section 144D.08, relating to uniform consumer information guide;

(23) section 144D.11, relating to emergency planning; and

(24) section 144.051, subdivisions 3 to 6.

Subd. 4. **Provisional license.** (a) Beginning July 1, 2021, for new assisted living license applicants, the commissioner shall issue a provisional license to each of the licensure levels specified in subdivision 2 which is effective for up to one year from the license effective date, except that a provisional license may be extended according to paragraph (d).

(b) During the provisional license period, the commissioner shall survey the provisional licensee after the commissioner is notified or has evidence that the provisional licensee has residents and is providing services.

(c) Within two days of beginning to provide services, the provisional licensee must provide notice to the commissioner that it is serving residents by sending an e-mail to the e-mail address provided by the commissioner. If the provisional licensee does not provide assisted living services during the provisional license year period, then the provisional license expires at the end of the period and the applicant must reapply for the provisional assisted living license.

(d) If the provisional licensee notifies the commissioner that the licensee has residents within 45 days prior to the provisional license expiration, the commissioner may extend the provisional license for up to 60 days in order to allow the commissioner to complete the on-site survey required under this section and follow-up survey visits.

(e) If the provisional licensee is in substantial compliance with the survey, the commissioner shall issue an assisted living license. If the provisional licensee is not in substantial compliance with the survey, the commissioner shall either: (1) not issue the assisted living license and terminate the provisional license; or (2) extend the provisional license for a period not to exceed 90 days and apply conditions, to the extension of the provisional license. If the provisional licensee is not in substantial compliance with the survey within the time period of the extension or if the provisional licensee does not satisfy the license conditions, the commissioner may deny the license.

(f) If a provisional licensee whose assisted living license has been denied or extended with conditions disagrees with the conclusions of the commissioner, then the provisional licensee may request a reconsideration by the commissioner or commissioner's designee. The reconsideration request process must be conducted internally by the commissioner or designee, and chapter 14 does not apply.

(g) The provisional licensee requesting the reconsideration must make the request in writing and must list and describe the reasons why the provisional licensee disagrees with the decision to deny the assisted living license or the decision to extend the provisional license with conditions.

(h) The reconsideration request and supporting documentation must be received by the commissioner within 15 calendar days after the date the provisional license receives the denial or provisional license with conditions.

(i) A provisional licensee whose license is denied is permitted to continue operating as an assisted living during the period of time when:

(1) a reconsideration is in process;

(2) an extension of the provisional license and terms associated with it is in active negotiation between the commissioner and the licensee and the commissioner confirms the negotiation is active; or

(3) a transfer of residents to a new assisted living establishment is underway and not all the residents have relocated.

Subd. 5. **License applications.** (a) Each application for an assisted living license, including a provisional license, must include information sufficient to show that the applicant meets the requirements of licensure, including:

(1) the business name and legal entity name of the operating entity, street address and mailing address of the assisted living; the names, e-mail addresses, telephone numbers, and mailing addresses of the owner or owners, direct and indirect, and managerial officials of the assisted living; and if the owner or owners are not natural persons, identification of the type of business entity of the owner or owners and the names, e-mail addresses, telephone numbers of the officers and members of the governing body, or comparable persons for partnerships, limited liability corporations, or other types of business organizations of the owner or owners;

(2) the name and mailing address of the managing agent, whether through management agreement or lease agreement, of the establishment, if different from the owner or owners, and the name of the on-site administrator;

(3) the license fee in the amount specified in subdivision 11;

(4) the e-mail address, physical address, mailing address, and telephone number of the principal administrative office;

(5) any state or federal court judgments, bankruptcy filings, tax liens, administrative actions, or investigations by any state or federal government agency against the applicant or the controlling person, or all persons involved in the management, operation, or control of the assisted living occurring within the last ten years;

(6) documentation of compliance with the background study requirements of section 144A.476 for the owner, controlling person, and all persons involved in the management, operation, or control of the assisted living establishment. Each application for a new license must include documentation for the applicant and for each individual with five percent or more direct or indirect ownership in the applicant;

(7) documentation of a background study as required by section 144.057 for any individual seeking employment, paid or volunteer, with the assisted living establishment;

(8) evidence of workers' compensation coverage as required by sections 176.181 and 176.182;

(9) documentation of liability coverage, if the provider has it;

(10) documentation that identifies the manager or operator who is in charge of day-to-day operations and attestation that the person has reviewed and understands the assisted living provider regulations;

(11) documentation that the applicant has designated one or more owners, controlling persons, or employees as an agent or agents, which shall not affect the legal responsibility of any other owner or controlling person under this chapter;

(12) the signature of the controlling person on behalf of the assisted living applicant;

(13) documentation of whether the assisted living health or supportive services are included in the monthly base rate to be paid by the resident;

(14) attestation that the applicant will comply with the prohibitions against deceptive marketing and business practices required by section 144I.21;

(15) documentation showing that the applicant has at least one year's worth of capital or revenue sufficient to operate the assisted living;

(16) verification that the applicant has the following policies and procedures in place so that if a license is issued, the applicant will implement the policies and procedures and keep them current:

(i) requirements in section 626.556, reporting of maltreatment of minors; and section 626.557, reporting of maltreatment of vulnerable adults;

(ii) conducting and handling background studies on employees;

(iii) orientation, training, and competency evaluations of assisted living staff, and a process for evaluating staff performance;

(iv) handling complaints from residents, family members, or resident representatives regarding staff or services provided by staff, the building, physical plant, or environment;

(v) conducting initial evaluation of residents' needs, move-in assessments, and the providers' ability to provide those services, including the services the residents request;

(vi) conducting initial and ongoing resident evaluations and assessments from a person-centered perspective, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate;

(vii) orientation to and implementation of the home care client bill of rights in sections 144A.44 and 144A.4791 with assisted living addendum;

(viii) infection control practices;

(ix) reminders for medications, treatments, or exercises, if provided as services;

(x) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards;

(xi) procedures about ensuring resident rights to information about and appeals from residency contracts and services terminations; and

(xii) policies and procedures for updating the staffing plan that ensures resident care needs are met, including a description of what factors are necessary to meet resident care needs and procedures for quality control reviews assessing the effectiveness of the staffing plans;

(17) for comprehensive and comprehensive PLUS applicants, in addition to the requirements in clause (16), the applicant must provide verification that the applicant has policies and procedures in place so that if a license is issued, the applicant will implement the policies and procedures and keep them current as required by section 144A.472, subdivision 2;

(18) identification of financial interest of any individual, including stockholders who have an incident of ownership in the applicant representing an interest of five percent or more. For the purposes of this chapter, an individual with a five percent or more direct or indirect ownership is presumed to have an effect on the operation of the facility with respect to factors affecting the care or training provided;

(19) identification of any individual with a five percent or more direct or indirect ownership that has ever been convicted of a crime associated with the operation of a long-term care, community-based, or health care facility or agency under federal law or the laws of any state;

(20) identification of all states where the applicant, or individual having a five percent or more ownership, currently or previously has been licensed as owner or operator of a long-term care, community-based, or health care facility or agency where its license or federal certification has been denied, suspended, restricted, conditioned, or revoked under a private or state-controlled receivership, or where these same actions are pending under the laws of any state or federal authority; and

(21) any other information required by the commissioner.

(b) If the owner of the facility is a different entity from the operator or management company of the facility, both the operator and the owner must complete an application for licensure for review under the same application process. Only one license fee is required.

Subd. 6. **Transfers prohibited; changes in ownership.** Any assisted living license issued by the commissioner may not be transferred to another party. Before acquiring ownership of an assisted living provider business, a prospective applicant must apply for a new license. A change of ownership is a transfer of operational control to a different business entity and includes:

(1) transfer of the business to a different or new corporation;

(2) in the case of a partnership, the dissolution or termination of the partnership under chapter 323A, with the business continuing by a successor partnership or other entity;

(3) relinquishment of control of the provider to another party, including to a contract management firm that is not under the control of the owner of the business's assets;

(4) transfer of the business by a sole proprietor to another party or entity; or

(5) in the case of a privately held corporation, the change in ownership or control of 50 percent or more of the outstanding voting stock.

Subd. 7. **License renewal.** Except as provided in section 144A.475, a license that is not a provisional license may be renewed for a period of one year if the licensee satisfies the following:

(1) submits an application for renewal in the format provided by the commissioner at least 60 days before expiration of the license;

(2) submits the renewal fee of $8,000;

(3) submits the late fee pursuant to subdivision 11 if the renewal application is received less than 30 days before the expiration date of the license;

(4) complies with sections 144A.43 to 144A.4798 and the provisions of this chapter;

(5) provides information sufficient to show that the applicant meets the requirements of licensure, including items required under subdivision 5;

(6) provides verification that all policies under subdivision 5 are current;

(7) updates the information required by subdivision 5, paragraph (a), clause (18); and

(8) provides any other information deemed necessary by the commissioner.

Subd. 8. **Notification of changes of information.** The provisional licensee or licensee shall notify the commissioner in writing prior to any financial or contractual change and within 60 calendar days after any change in the information required in subdivision 5.

Subd. 9. **Actions on licenses.** (a) The commissioner shall consider an applicant's performance history, in Minnesota and in other states, including repeat violations or rule violations, before issuing a provisional license, license, or renewal license.

(b) An applicant must not have a history within the last five years in Minnesota or in any other state of a license or certification involuntarily suspended or voluntarily terminated during any enforcement process in a facility that provides care to children, the elderly or ill individuals, or individuals with disabilities.

(c) Failure to provide accurate information or demonstrate required performance history may result in the denial of a license.

(d) The commissioner may deny, revoke, suspend, restrict, or refuse to renew the license or impose conditions if:

(1) the applicant fails to provide complete and accurate information on the application and the commissioner concludes that the missing or corrected information is needed to determine if a license shall be granted;

(2) the assisted living, knowingly or with reason to know, made a false statement of a material fact in an application for the license or any data attached to the application, or in any matter under investigation by the department;

(3) the assisted living refused to allow representatives or agents of the department to inspect its books, records, and files, or any portion of the premises;

(4) willfully prevented, interfered with, or attempted to impede in any way: (i) the work of any authorized representative of the department, the ombudsman for long-term care or the ombudsman for mental health and developmental disabilities; or (ii) the duties of the commissioner, local law enforcement, city or county attorneys, adult protection, county case managers, or other local government personnel;

(5) the assisted living has been the subject of a substantiated maltreatment violation, had level 2 widespread determination on a survey, had a level 3 or level 4 violation as specified in section 144A.474, subdivision 11, or the assisted living engaged in conduct that was detrimental to the health, welfare, or safety of the resident;

(6) the assisted living has a history of noncompliance with federal or state regulations in providing care or services. The factors the commissioner may consider include but are not limited to the gravity and frequency of the noncompliance; and

(7) the assisted living engages in conduct in section 144A.475, subdivision 1; or

(8) the assisted living violates any requirement in this chapter.

(e) For all new licensees after a change in ownership, the commissioner shall complete a survey within six months after the new license is issued.

Subd. 10. **Fees.** (a) An initial applicant seeking assisted living licensure must submit the following application fee to the commissioner along with a completed application:

(1) for a basic assisted living facility providing basic home care services, $5,500;

(2) for a comprehensive assisted living facility providing comprehensive home care services, $9,500; and

(3) for a comprehensive PLUS assisted living facility providing comprehensive home care services and dementia care, $14,250.

(b) An assisted living filing a change of ownership as required under subdivision 6 must submit the following application fee to the commissioner, along with the documentation required for the change of ownership:

(1) for a basic assisted living, $5,500;

(2) for a comprehensive assisted living, $9,500; or

(3) for a comprehensive PLUS assisted living, $10,000.

(c) The penalty for late submission of the renewal application before expiration of the license is $200. The penalty for practicing after expiration of the assisted living license and before a renewal license is issued is $250 per each day after expiration of the license until the renewal license issuance date. The assisted living is still subject to the criminal gross misdemeanor penalties for operating after license expiration.

(d) Fees collected under this section shall be deposited in the state treasury and credited to the state government special revenue fund. All fees are nonrefundable.

(e) Fines collected under this subdivision shall be deposited in a dedicated special revenue account. On an annual basis, the balance in the special revenue account shall be appropriated to the commissioner to implement the recommendations of the advisory council established in section 144A.4799.

Sec. 3. **[144I.03] ASSISTED LIVING LICENSES PRACTICE REQUIREMENTS.**

Subdivision 1. **Requirements.** All licensed assisted living shall:

(1) distribute to residents, families, and resident representatives and enforce the home care bill of rights requirements in section 144A.44 and the assisted living bill of rights in section 144A.441 except that the advance notice period for termination of housing and services shall be no less than 30 days;

(2) provide health-related services in a manner that complies with applicable home care licensure requirements in chapter 144A and the Nurse Practice Act in sections 148.171 to 148.285;

(3) utilize person-centered planning and service delivery process as defined in section 245D.07;

(4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by applicable home care licensure requirements in chapter 144A and the Nurse Practice Act in sections 148.171 to 148.285;

(5) have, maintain, and document a system to visually check on each assisted living resident a minimum of once daily or more than once daily depending on the person-centered care plan;

(6) provide a means for assisted living residents to request assistance for health and safety needs 24 hours per day, seven days per week;

(7) have an on-site registered nurse or licensed practical nurse available 24 hours per day, seven days per week, who is responsible for responding to the requests of assisted living residents for assistance with health or safety needs, who shall be:

(i) awake;

(ii) located in the same building, in an attached building, or on a contiguous campus with the housing with services establishment in order to respond within a reasonable amount of time;

(iii) capable of communicating with assisted living residents; and

(iv) capable of providing either the assistance required or, if the person on-site is a licensed practical nurse, have access to an on-call registered nurse;

(8) offer to provide or make available at least the following supportive services to assisted living residents:

(i) at least two daily nutritious meals with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply:

(A) modified special diets that are appropriate to residents' needs and choices;

(B) menus prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes;

(C) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and

(D) the assisted living cannot require a resident to include and pay for meals in their residency contract;

(ii) weekly housekeeping;

(iii) weekly laundry service;

(iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the person or persons responsible for providing this assistance;

(v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about the person or persons responsible for providing this assistance; and

(vi) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large;

(9) make available to all prospective and current assisted living clients a copy of the uniform consumer information guide required by section 144G.06;

(10) maintain a safe, clean, sanitary, functional, comfortable, and home-like physical environment; and

(11) establish and maintain an infection control program.

Subd. 2. **Nursing assessment.** (a) A licensed assisted living shall:

(1) have the arranged home care provider conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with an assisted living establishment or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the provider, or urgent or unexpected circumstances exist, the assessment may be conducted using telecommunication methods based on practice standards that meet the individual resident's needs and reflect person-centered planning and service delivery; and

(2) inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911 prior to the date on which a prospective resident executes a contract with a licensed assisted living establishment or the date on which a prospective resident moves in, whichever is earlier.

(b) The arranged home care provider shall comply with applicable home care licensure requirements in chapter 144A and the Nurse Practice Act in sections 148.171 to 148.285 with respect to conducting a nursing assessment prior to the delivery of nursing services and the execution of a home care service plan or service agreement.

Subd. 3. **Services oversight and information.** The assisted living shall provide each assisted living resident with identifying and contact information about the persons who can assist with health care or supportive services being provided. The assisted living shall keep each resident informed of changes in personnel referenced in this subdivision.

Subd. 4. **Governing body.** Every basic, comprehensive, and comprehensive PLUS assisted living licensee shall have a governing body that assumes full legal responsibility for determining, implementing, and monitoring policies governing the licensee's operation.

Subd. 5. **Administrator.** Every basic, comprehensive, and comprehensive PLUS assisted living licensee shall have an administrator who is responsible for: (1) the day-to-day management of both the housing and the services provided including the overall responsibility for the medical services components for comprehensive and comprehensive PLUS; (2) implementing the policies and procedures; and (3) leading the staff.

Subd. 6. **Clinical nurse supervision.** All comprehensive and comprehensive PLUS licensees must have a clinical nurse supervisor who is a registered nurse licensed in Minnesota.

Subd. 7. **Resident councils.** All basic, comprehensive, and comprehensive PLUS licensees shall establish both a resident council whose members are residents living at that location and a family or resident representative council. The licensee shall support the

council's establishment and provide meeting space; materials; any necessary equipment such as computers, printers, and assistive listening devices for use with hearing aids; microphones; and tables. The licensee shall offer a staff person to attend to take minutes for the council. Resident council minutes are public data and must be available to all residents in the assisted living. Family or resident representatives may attend resident councils if invited by a resident on the council.

Subd. 8. **Resident grievances.** All basic, comprehensive, and comprehensive PLUS licensees must post in a conspicuous place information about the assisted living's grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Minnesota Adult Abuse Reporting Center, the common entry point, and the state and applicable regional Office of Ombudsman for Long-Term Care.

Subd. 9. **Reporting suspected crime and maltreatment.** An assisted living shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by:

(1) posting the 911 emergency number in common areas and near telephones provided by the assisted living;

(2) posting information and the reporting number for the common entry point to report suspected maltreatment of a vulnerable adult under section 626.557; and

(3) providing reasonable accommodations with information and notices in plain language.

Subd. 10. **Protecting resident rights.** An assisted living shall ensure that every resident has access to consumer advocacy or legal services by:

(1) encouraging and assisting each resident to access these protection services;

(2) providing names and contact information, including telephone numbers and e-mail addresses of at least three individuals or organizations that provide advocacy or legal services to residents;

(3) providing the name and contact information for the Minnesota Office of Ombudsman for Long-Term Care, including both the state and regional contact information;

(4) making every effort to assist residents in obtaining information on whether Medicare or medical assistance will pay for services;

(5) making reasonable accommodations for people who have communication disabilities and those who speak a language other than English; and

(6) providing all information and notices in plain language and in terms the residents can understand.

Subd. 11. **Protection-related rights.** (a) In addition to the rights required in sections 144A.44 and 144A.441, the following rights must be provided to all assisted living residents. The assisted living must promote and protect these rights for each resident by making residents aware of these rights and ensuring staff are trained to support these rights:

(1) the right to furnish and decorate the resident's unit within the terms of the lease;

(2) the right to access food at any time;

(3) the right to choose visitors and the times of visits;

(4) the right to choose a roommate if sharing a unit;

(5) the right to personal privacy including the right to have and use a lockable door on the resident's unit. The assisted living provider shall provide the locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible;

(6) the right to engage in chosen activities;

(7) the right to engage in community life;

(8) the right to control personal resources; and

(9) the right to individual autonomy, initiative, and independence in making life choices including a daily schedule and with whom to interact.

(b) The resident's rights in paragraph (a), clauses (2), (3), and (5), may be restricted for an individual resident only if determined necessary for health and safety reasons identified by the assisted living provider through an initial assessment or reassessment, as defined under section 144A.4791 and documented in the written service plan under section 144A.43. Any restrictions of those rights for people served under sections 256B.0915 and 256B.49 must be documented by the case manager in the resident's coordinated service and support plan (CSSP), as defined in sections 256B.0915, subdivision 6, and 256B.49, subdivision 15.

Subd. 12. **Retaliation prohibited.** (a) An assisted living must not retaliate by taking an adverse action against a resident, resident representative, assisted living employee, or other interested person who:

(1) files a complaint or grievance or asserts any rights on behalf of themselves or the resident;

(2) submits a report to law enforcement, the common entry point, or any other agency, whether voluntarily or due to a mandatory reporting requirement;

(3) advocates on behalf of the resident for services or enforcement of the resident's rights; or

(4) enters into a contract with a home care provider, health professional, or pharmacy of the person's own choice who is not the arranged or preferred provider associated with the assisted living.

(b) For purposes of this section, "adverse action" means an action taken by the assisted living and its agents, including but not limited to:

(1) discharging or transferring from the assisted living, or terminating services or the residency contract;

(2) discharging from or terminating employment or demoting unless for good cause;

(3) suddenly establishing new fees or increasing fees or costs for services when the costs are not also applied to all residents;

(4) restricting access to or use of amenities or services;

(5) infringing or violating any resident rights in the client bills of rights as required by sections 144A.44 and 144A.441;

(6) communicating verbally or in writing to the assisted living employees or residents and their families false information about any person who advocated on behalf of the resident; and

(7) restricting or prohibiting access to the assisted living or to the resident, including issuing a no trespass order under section 609.605.

Subd. 13. **Payment for services under disability waivers.** For new assisted living as defined in section 144I.01, home and community-based services under section 256B.49 are not available when the new assisted living setting is adjoined to, or on the same property as, an institution as defined by the Federal Centers for Medicare and Medicaid Services in Code of Federal Regulations, title 42, section 441.301(c).

EFFECTIVE DATE. This section is effective July 1, 2021.

Sec. 4. **[144I.04] MANAGEMENT AGREEMENTS; GENERAL REQUIREMENTS.**

Subdivision 1. **Notification.** (a) If the proposed or current licensee uses a manager, the licensee must have a written management agreement that is consistent with this chapter.

(b) The proposed or current licensee must notify the commissioner of its use of a manager upon:

(1) initial application for a license;

(2) retention of a manager following initial application;

(3) change of managers; and

(4) modification of an existing management agreement.

(c) The proposed or current licensee must provide to the commissioner a written management agreement, including an organizational chart showing the relationship between the proposed or current licensee, management company, and all related organizations.

(d) The written management agreement must be submitted:

(1) 60 days before:

(i) the initial licensure date;

(ii) the proposed change of ownership date; or

(iii) the effective date of the management agreement; or

(2) 30 days before the effective date of any amendment to an existing management agreement.

(e) The proposed licensee or the current licensee must notify the residents and their representatives 60 days before entering into a new management agreement.

(f) A proposed licensee must submit a management agreement attestation form, as required by the assisted living application.

Subd. 2. **Management agreement; licensee.** (a) The licensee is responsible for:

(1) the daily operations and provisions of services in the assisted living;

(2) ensuring the assisted living is operated in a manner consistent with all applicable laws and rules;

(3) ensuring the manager acts in conformance with the management agreement; and

(4) ensuring the manager does not present as, or give the appearance that the manager is the licensee.

(b) The licensee must not give the manager responsibilities that are so extensive that the licensee is relieved of daily responsibility for the daily operations and provision of services

in the assisted living facility. If the licensee does so, the commissioner must determine that a change of ownership has occurred.

(c) The licensee and manager must act in accordance with the terms of the management agreement. If the commissioner determines they are not, then the department may impose enforcement remedies.

(d) The licensee may enter into a management agreement only if the management agreement creates a principal/agent relationship between the licensee and manager.

Subd. 3. **Terms of agreement.** A management agreement at a minimum must:

(1) describe the responsibilities of the licensee and manager, including items, services, and activities to be provided;

(2) require the licensee's governing body, board of directors, or similar authority to appoint the administrator;

(3) provide for the maintenance and retention of all records in accordance with this chapter and other applicable laws;

(4) allow unlimited access by the commissioner to documentation and records according to applicable laws or regulations;

(5) require the manager to immediately send copies of inspections and notices of noncompliance to the licensee;

(6) state that the licensee is responsible for reviewing, acknowledging, and signing all assisted living initial and renewal license applications;

(7) state that the manager and licensee shall review the management agreement annually and notify the commissioner of any change according to applicable regulations;

(8) acknowledge that the licensee is the party responsible for complying with all laws and rules applicable to the assisted living;

(9) require the licensee to maintain ultimate responsibility over personnel issues relating to the operation of the assisted living and care of the residents including but not limited to staffing plans, hiring, and performance management of employees, orientation, and training;

(10) state the manager will not present as, or give the appearance that the manager is the licensee; and

(11) state that a duly authorized manager may execute resident leases or agreements on behalf of the licensee, but all such resident leases or agreements must be between the licensee and the resident.

Subd. 4. **Commissioner review.** The commissioner may review a management agreement at any time. Following the review, the department may require:

(1) the proposed or current licensee or manager to provide additional information or clarification;

(2) any changes necessary to:

(i) bring the management agreement into compliance with this chapter; and

(ii) ensure that the licensee has not been relieved of the responsibility for the daily operations of the assisted living; and

(3) the licensee to participate in monthly meetings and quarterly on-site visits to the assisted living.

Subd. 5. **Resident funds.** (a) If the management agreement delegates day-to-day management of resident funds to the manager, the licensee:

(1) retains all fiduciary and custodial responsibility for funds that have been deposited with the assisted living by the resident;

(2) is directly accountable to the resident for such funds; and

(3) must ensure any party responsible for holding or managing residents' personal funds is bonded or obtains insurance in sufficient amounts to specifically cover losses of resident funds and provides proof of bond or insurance.

(b) If responsibilities for the day-to-day management of the resident funds are delegated to the manager, the manager must:

(1) provide the licensee with a monthly accounting of the resident funds; and

(2) meet all legal requirements related to holding and accounting for resident funds.

Sec. 5. **[144I.05] MINIMUM SITE REQUIREMENTS AND FIRE SAFETY.**

Subdivision 1. **Site requirements.** (a) Effective July 1, 2019, the following items are required:

(1) each assisted living must be located so that all residents are protected in their health, comfort, and safety;

(2) public utilities must be available and working;

(3) inspected and approved water and septic systems are in place;

(4) the location of the assisted living is located no closer than 300 feet to the right-of-way of a railroad mainline or to the property line of industrial sites that are hazardous to health;

(5) the location of the assisted living is not located within 85 feet of underground or 300 feet of aboveground storage tanks or warehouses containing flammable liquids;

(6) the location of the assisted living is publicly accessible to fire department services and emergency medical services;

(7) the topography of the location of the assisted living provides good natural drainage and is not subject to flooding;

(8) all-weather roads and walks are within the lot lines to the primary entrance and the service entrance, including employees' and visitors' parking at the site;

(9) the primary entrance is accessible for persons with disabilities; and

(10) the location of the assisted living includes space for outdoor activities for residents.

(b) The assisted living must be in compliance with all applicable state and local laws, regulation standards, ordinances, codes for fire safety, and building, accessibility, and zoning requirements including ongoing obligations under the Americans with Disabilities Act and the Minnesota Human Rights Act.

Subd. 2. **Fire protection.** (a) Effective July 1, 2019, each assisted living building must have a comprehensive fire protection system that includes:

(1) protection throughout by an approved, supervised automatic sprinkler system according to building code requirements established in Minnesota Rules, part 1305.0903, or smoke detectors installed in each occupiable room and maintained in accordance with NFPA 72; and

(2) portable fire extinguishers installed and tested in accordance with NFPA 10.

(b) Beginning July 1, 2019, fire drills must be conducted in accordance with the residential board and care requirements in the Life Safety Code.

(c) After June 30, 2022, all new construction in an assisted living must meet the provisions relevant to licensed assisted living in the most current edition of the Facility Guidelines Institute's Guidelines for Design and Construction of Residential Health, Care and Support

Facilities and of adopted rules. In addition to the guidelines, assisted livings shall provide the option of a bath in addition to a shower for all residents.

(d) For all new construction beginning July 1, 2022, the requirements in clauses (1) to (7) must be provided to the commissioner:

(1) Architectural and engineering plans and specifications for new construction must be prepared and signed by architects and engineers who are registered in Minnesota. Final working drawings and specifications for proposed construction must be submitted to the commissioner for review and approval.

(2) Preliminary plans must be drawn in scale, show basic dimensions, and indicate the general layout and space arrangement of the proposed building or area and must include a site plan when applicable. Plans must indicate assignments of rooms and areas, and must show bed capacities and fixed equipment.

(3) Final architectural plans and specifications must include elevations and sections throughout the building showing types of construction, and must indicate dimensions and assignment of rooms and areas, room finishes, door types and hardware, elevations and details of nurses' work areas, utility rooms, toilets and bathing areas, and large-scale layouts of dietary and laundry areas. Plans must show the location of fixed equipment and sections and details of elevators, chutes, and other conveying systems. Fire walls and smoke partitions must be indicated. The roof plan must show all mechanical installations. The site plan must indicate the proposed and existing buildings, topography, roadways, walks, and utility service lines.

(4) Final mechanical and electrical plans and specifications must address the complete layout and type of all installations, systems, and equipment to be provided. Heating plans must include heating elements, piping, thermostatic controls, pumps, tanks, heat exchangers, boilers, breeching, and accessories. Ventilation plans must include room air quantities, ducts, fire and smoke dampers, exhaust fans, humidifiers, and air handling units. Plumbing plans must include a fixtures and equipment fixture schedule; water supply and circulating piping, pumps, tanks, riser diagrams, and building drains; the size, location, and elevation of water and sewer services; and the building fire protection systems. Electrical plans must include fixtures and equipment, receptacles, switches, power outlets, circuits, power and light panels, transformers, and service feeders. Plans must show the location of nurse call signals, cable lines, fire alarm stations, and detectors and emergency lighting.

(5) Unless construction is begun within one year after approval of the final working drawing and specifications, the drawings must be resubmitted for review and approval. All

construction must be executed according to the approved final plans and specifications. Subsequent construction changes must be made in accordance with the adopted requirements, and must be reviewed by the commissioner before the changes are made.

(6) The commissioner must be notified within 30 days before completion of construction so that the commissioner can make arrangements for a final inspection by the commissioner.

(7) At least one set of complete life safety plans including changes resulting from remodeling or alterations must be kept on file in the assisted living.

(e) After July 1, 2022, all newly licensed buildings where assisted living services are provided must ensure that 20 percent of the assisted living resident rooms are accessible under the Minnesota Accessibility Code.

(f) An assisted living may request that the commissioner grant a variance or waiver from the provisions of this section. A request for a waiver must be submitted to the commissioner in writing. Each request must contain:

(1) the specific requirement for which the variance or waiver is requested;

(2) the reasons for the request;

(3) the alternative measures that will be taken if a variance or waiver is granted;

(4) the length of time for which the variance or waiver is requested; and

(5) other relevant information deemed necessary by the commissioner to properly evaluate the request for the waiver.

(g) The decision to grant or deny a variance or waiver must be based on the commissioner's evaluation of the following criteria:

(1) whether the waiver will adversely affect the health, treatment, comfort, safety, or well-being of a patient;

(2) whether the alternative measures to be taken, if any, are equivalent to or superior to those prescribed in this section; and

(3) whether compliance with any requirement would impose an undue burden upon the applicant.

Sec. 6. **[144I.06] RESIDENCY CONTRACT REQUIREMENTS.**

Subdivision 1. **Contract required.** (a) No assisted living may operate in Minnesota unless a written residency contract is executed between the assisted living licensee and each

resident or resident's representative and unless the assisted living complies with the terms of the contract.

(b) No other lease or contract shall be in effect in addition to the residency contract.

Subd. 2. **Contents.** A residency contract, which must be titled as such, shall include the following items:

(1) the name, street address, and mailing address of the assisted living;

(2) the name and mailing address of the owner or owners of the assisted living and if the owner or owners are not a natural person, identification of the type of business entity of the owner or owners;

(3) the name and mailing address of the managing agent through a management agreement or lease agreement if different from the owner or owners;

(4) the name and address of at least one natural person who is authorized to accept service of process on behalf of the owner or owners and managing agent;

(5) the name and contact information for 24 hours per day, seven days per week, for the administrator, clinical nurse supervisor, registered nurse manager, governing body members, and a statement that this information is subject to change and whenever there is a change, the assisted living will notify each resident within one week of the change;

(6) a statement describing the registration and licensure status of the location and any provider providing health-related or supportive services;

(7) the term period of the contract;

(8) a description of the services to be provided to the resident and the base rate to be paid for the resident including a delineation of the portion of the base rate that constitutes rent and a delineation of charges for each service included in the base rate;

(9) a description of any additional services, including home care services available for additional fees from the assisted living directly or through arrangements with the assisted living, and a schedule of fees charged for these services;

(10) a conspicuous notice informing the resident of policies concerning the conditions under which the process for modifying the resident contract including whether a move to a different room or sharing a room would be required in the event the resident can no longer pay the service fees or rent;

(11) a description of the assisted living's policies related to medical assistance waivers under sections 256B.0915 and 256B.092, including:

(i) whether the provider is enrolled with the Department of Human Services to provide customized living services under medical assistance waivers;

(ii) whether there is a limit on the number of people residing at the assisted living who can receive customized living services at any point in time. If so, the limit must be provided;

(iii) a statement explaining that medical assistance waivers provide payment for services, but do not cover the cost of rent;

(iv) a statement explaining that residents may be eligible for assistance with rent through the housing support program; and

(v) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program;

(12) a description of the assisted living's internal complaint process including the names and contact information of staff who may receive complaints, plus the toll-free complaint line for the Office of Ombudsman for Long-Term Care;

(13) billing and payment procedures and requirements;

(14) a statement regarding the freedom of choice a resident has to choose services from providers they want and that there will be no additional fees imposed by the assisted living for making those choices;

(15) the service agreement shall be attached to the residency contract when the service agreement is completed.

Subd. 3. **Filing.** Residency contracts will be maintained by the assisted living in files from the date of execution until three years after the contract is terminated. The contracts and all associated documents will be available for on-site inspection by the commissioner at any time. The documents shall be available for viewing or copies shall be made available to the resident and resident's representative at any time.

Sec. 7. **[144I.07] RESIDENCY CONTRACT TERMINATION.**

Subdivision 1. **Limitations.** (a) An assisted living licensee may terminate a residency contract only if:

(1) the resident has not paid the rent;

(2) the safety or health of other individuals in the assisted living is endangered;

(3) the assisted living licensee intends to cease operation; or

(4) the assisted living's license is being restricted by the commissioner of health or human services.

A breach of a service agreement does not constitute a breach of a residency contract.

(b) Prior to terminating a residency contract, an assisted living licensee must provide a resident with at least:

(1) 30 days' advance written notice of termination in cases of nonpayment of rent;

(2) 30 days' advance written notice of termination in cases of alleged breach of contract;

(3) 60 days' advance written notice of closure of the assisted living licensee unless the closure is due to a commissioner license enforcement action pursuant to section 144I.02, subdivision 9; and

(4) a comprehensive discharge plan.

(c) Notwithstanding paragraphs (a) and (b), an assisted living licensee may immediately commence residency contract termination if:

(1) the alleged breach involves any of the acts listed in section 504B.171, subdivision 1;

(2) the assisted living resident holds over beyond the date to vacate mutually agreed upon in writing by the resident and the assisted living licensee; or

(3) the assisted living resident holds over beyond the date provided by the resident to the assisted living licensee in a notice of voluntary termination of the lease. The resident retains their appeal rights pursuant to subdivision 3.

(d) Nothing in this section affects other rights and remedies available under chapter 504B.

Subd. 2. **Contents of notice.** (a) The notice required under subdivision 1 must include:

(1) a detailed explanation of the reason for the termination;

(2) the date termination will occur;

(3) an adequate and safe discharge location; and

(4) a statement that the recipient of the notice may contact the Office of Ombudsman for Long-Term Care regarding the residency contract termination issues and the address and telephone number of the Office of Ombudsman for Long-Term Care, the Office of Administrative Hearings, and a protection and advocacy agency.

(b) The notice must also include the following statements:

(1) that the resident has a right to request a meeting with the assisted living licensee to discuss and attempt to resolve the alleged breach to avoid termination;

(2) that the resident has a right to appeal the termination of the residency contract to the Office of Administrative Hearings and the date and time by which the resident must submit an appeal request;

(3) that the resident has a right to avoid termination of the residency contract by paying the rent in full within ten days of receiving written notice of nonpayment; and

(4) that the resident has the right to cure the breach within 30 days of receiving written notice of the breach.

Subd. 3. **Right to appeal termination of the residency contract.** (a) At any time prior to the expiration of the notice period provided under subdivision 2, a resident may appeal the termination by making a written request for a hearing to the Office of Administrative Hearings, which must schedule the hearing no later than 14 days after receiving the appeal request. In the case of an immediate notice of eviction, the resident has ten days to appeal after receipt of the notice to appeal. The hearing must be held at the location where the resident resides, unless it is impractical or the parties agree otherwise. The hearing is not a formal evidentiary hearing. The hearing may be attended by telephone as allowed by the administrative law judge. The hearing shall be limited to the amount of time necessary for the participants to expeditiously present the facts about the proposed termination. The administrative law judge shall issue a recommendation to the commissioner within ten business days after the hearing. Attorney representation is not required at the hearing nor does appearing without an attorney constitute the unauthorized practice of law.

(b) A resident who makes a timely appeal of a notice of residency contract termination may not be evicted by the assisted living licensee until the Office of Administrative Hearings makes a final determination on the appeal in favor of the assisted living licensee.

(c) The commissioner may direct the assisted living licensee to rescind the residency contract termination or readmit the resident if:

(1) the residency contract termination was in violation of state or federal law;

(2) the resident cures the alleged breach of lease or pays the rent owed on or before the date of the administrative hearing; or

(3) the discharge plan is in violation of state or federal law.

(d) The assisted living licensee must readmit the resident if the resident is hospitalized for medical necessity before the resolution of the appeal.

(e) Residents are not required to request a meeting as provided in subdivision 2 prior to submitting an appeal hearing request.

(f) Nothing in this section limits the rights of a resident or the resident's representative to request or receive assistance from the Office of Ombudsman for Long-Term Care and a protection and advocacy agency concerning the proposed residency contract termination.

Subd. 4. **Discharge plan and transfer of information to new residence.** (a) Sufficiently in advance of discharging a resident, an assisted living licensee must prepare an adequate discharge plan that:

(1) is based on the resident's discharge goals;

(2) includes in discharge planning the resident, the resident's case manager, and the resident's representative, if any;

(3) contains a plan for appropriate and sufficient postdischarge care; and

(4) proposes a safe discharge location which does not include a private home where the occupant is unwilling or unable to care for the resident, a homeless shelter, a hotel, or a motel.

(b) An assisted living licensee may not discharge a resident if the resident will, upon discharge, become homeless as defined in section 116L.361, subdivision 5.

(c) An assisted living licensee that proposes to discharge a resident must assist the resident with applying for and locating a safe and adequate discharge location, including coordinating with the county case manager, if any.

(d) Prior to discharge, an assisted living licensee must provide to the receiving facility or setting all information known to the licensee related to the resident that is necessary to ensure continuity of care and services including, at a minimum:

(1) the resident's full name, date of birth, and insurance information;

(2) the name, telephone number, and address of the resident's representative, if any;

(3) the resident's current documented diagnoses;

(4) the resident's known allergies;

(5) the name and telephone number of the resident's physician and the current physician orders, if known;

(6) any and all medication administration records;

(7) the most recent resident assessment; and

(8) copies of health care directives, do not resuscitate orders, and any guardianship orders or powers of attorney.

(e) For purposes of this subdivision, "discharge" means the involuntary relocation of a resident due to a termination of a residency contract. If a residential contract is initiated by the assisted living provider, it is considered a discharge.

Subd. 5. **Final accounting; return of money and property.** (a) Within 30 days of the date of discharge, the assisted living licensee shall:

(1) provide to the resident or resident's representative a final statement of account;

(2) provide any refunds due; and

(3) return any money, property, or valuables held in trust or custody by the assisted living licensee.

(b) As required by section 504B.178, an assisted living licensee may not collect a nonrefundable security deposit unless it is applied to the first month's charges.

Sec. 8. **[144I.08] TERMINATION OF SERVICES; ARRANGED HOME CARE PROVIDER.**

Subdivision 1. **Notice; permissible reason to terminate services.** (a) Except as provided in paragraph (b), the assisted living must provide at least 30 days' notice prior to terminating a service contract. Notwithstanding any other provision of law, the assisted living may terminate services only if:

(1) the resident engages in conduct that interferes with the assisted living's ability to carry out the terms of the service plan and cannot be cured by updating or changing the terms of the service plan; or

(2) the resident fails to pay for services, provided the resident has not cured the breach within 30 days of receiving written notice of nonpayment.

(b) Notwithstanding paragraph (a), the assisted living may terminate services with ten days' notice if a doctor or treating physician documents that an emergency or a significant change in the resident's condition has resulted in service needs that exceed the current service plan and that cannot be safely met by the assisted living. In this situation, the assisted living

must assist the resident in obtaining services from a home care provider wherever the resident chooses to receive the services.

(c) If the license of the assisted living is restricted by the commissioner, then the licensee must follow the directions of the commissioner for ceasing services to residents and the notice provisions in this subdivision may not apply.

Subd. 2. **Contents of service termination notice.** If an arranged home care provider who is not Medicare certified terminates a service agreement or service plan with a resident in an assisted living setting, the home care provider shall provide the resident and the legal representative or resident representative, if any, with advance written notice of service termination according to subdivision 1 that must include:

(1) the effective date of service termination;

(2) the reason for service termination;

(3) without extending the termination notice period, an affirmative offer to meet with the resident or the resident's representative within five business days of the date of the service termination notice to discuss the termination;

(4) contact information for other assisted living licensees in the geographic area of the resident;

(5) a statement that the provider will participate in a coordinated transfer of care of the client to another provider;

(6) a statement that the resident has a right to request a meeting with the arranged home care provider to discuss and attempt to avoid the service termination;

(7) the name and contact information of a representative of the arranged home care provider with whom the resident may discuss the notice of service termination;

(8) a copy of the home care bill of rights;

(9) a statement that the notice of service termination of home care services by the home care provider does not constitute notice of termination of the lease of the assisted living; and

(10) a statement that the recipient of the notice may contact the Office of Ombudsman for Long-Term Care regarding the lease termination issues and a statement that the resident has the right to appeal the service termination to the Office of Administrative Hearings and provide the contact information for the Office of Administrative Hearings, including the mailing address, fax number, e-mail address, and telephone number.

Subd. 3. **Right to appeal service termination.** (a) At any time prior to the expiration of the notice period provided in subdivision 1, a resident may appeal the service termination by making a written request for a hearing to the Office of Administrative Hearings. The Office of Administrative Hearings must conduct the hearing no later than 14 days after the office receives the appeal request from the resident. The hearing must be held in the place where the resident resides unless it is impractical or the parties agree to a different place. Attorney representation is not required at the hearing, nor does appearing without an attorney constitute the unauthorized practice of law. The hearing is not a formal evidentiary hearing. The hearing may also be attended by telephone as allowed by the administrative law judge. The hearing shall be limited to the amount of time necessary for the participants to expeditiously present the facts about the proposed termination. The administrative law judge shall issue a recommendation to the commissioner within ten business days after the hearing.

(b) The arranged home care provider may not discontinue services to a resident who timely appeals a notice of service termination until the Office of Administrative Hearings has made a final determination on the appeal in favor of the assisted living licensee.

(c) Residents are not required to request a meeting under subdivision 1 prior to submitting a request for an appeal hearing.

(d) The commissioner may direct the assisted living licensee to rescind the service contract termination if the Office of Administrative Hearings decides that the proposed termination was in violation of state or federal law.

(e) Nothing in this section limits the right of a resident or a resident's representative to request or receive assistance from the Office of Ombudsman for Long-Term Care and a protection and advocacy agency concerning the proposed service termination.

Sec. 9. **[144I.09] RELOCATIONS WITHIN ASSISTED LIVING LOCATION.**

Subdivision 1. **Notice required before relocation within location.** An assisted living licensee must:

(1) notify a resident and the resident's representative, if any, at least 14 days prior to a proposed nonemergency relocation to a different room at the same location; and

(2) obtain consent from the resident and the resident's representative, if any.

A resident must be allowed to stay in the resident's room or reasonable modifications must be made to another room to accommodate the resident.

Subd. 2. **Evaluation.** An assisted living licensee shall evaluate the resident's individual needs before deciding whether the room the resident will be moved to fits the resident's psychological, cognitive, and health care needs, including the accessibility of the bathroom.

Subd. 3. **Restriction on relocation.** A person who has been a private-pay resident for at least one year and resides in a private room, and whose payments subsequently will be made under the medical assistance program, may not be relocated to a shared room without the consent of the resident or the resident's representative, if any.

Sec. 10. **[144I.10] COMMISSIONER OVERSIGHT AND AUTHORITY.**

(a) The commissioner shall license, survey, and monitor without advance notice assisted living licensees in accordance with this chapter.

(b) The commissioner shall survey assisted living licensees on a frequency of once per year.

(c) After July 1, 2022, the commissioner shall provide blueprint review for all new assisted living construction and must approve the plans before construction is commenced.

(d) The commissioner shall provide on-site reviews of the construction to ensure that all physical plant standards are met before the assisted living license is complete.

Sec. 11. **[144I.11] EXPEDITED RULEMAKING AUTHORIZED.**

(a) The commissioner shall adopt rules for all assisted living licenses that promote person-centered planning and service and optimal quality of life, and that ensure resident rights are protected, resident choice is allowed, and public health and safety is ensured.

(b) On July 1, 2019, the commissioner shall begin expedited rulemaking using the process in section 14.389, except that the rulemaking process is exempt from section 14.389, subdivision 5.

(c) The commissioner shall adopt rules that include but are not limited to the following:

(1) building design, physical plant standards, environmental health and safety minimum standards from the most recent version of the Facility Guide Institute's Guidelines for Design and Construction of Residential Health, Care, and Support Facilities, including appendices;

(2) staffing minimums and ratios for each level of licensure to best protect the health and safety of residents no matter their vulnerability;

(3) require provider notices and disclosures to residents and their families;

(4) training prerequisites and ongoing training for administrators and caregiving staff;

(5) minimum requirements for move-in assessments and ongoing assessments and practice standards in sections 144A.43 to 144A.47;

(6) requirements for licensees to ensure minimum nutrition and dietary standards required by section 144I.03 are provided;

(7) requirements for supportive services provided by assisted living licensees;

(8) identifying personnel in assisted living providers aside from those already required to obtain background studies as required in sections 144.057, 144.0572, 144A.476, and 144I.02 who need to obtain background studies and establish a process for obtaining those results;

(9) procedures for discharge planning and ensuring resident appeal rights;

(10) procedures for ensuring that licensees establish resident and family councils;

(11) content requirements for all license or provisional license applications;

(12) requirements that support for assisted living providers to comply with home and community-based requirements in Code of Federal Regulations, title 42, section 441.301(c);

(13) core dementia care requirements and training in all levels of licensure;

(14) requirements for a comprehensive PLUS license in terms of training, care standards, noticing changes of condition, assessments, and health care; and

(15) preadmission criteria, initial assessments, and continuing assessments.

(d) The commissioner shall publish the proposed rules by December 31, 2019, and shall publish final rules by December 31, 2020.

Sec. 12. **TRANSITION PERIOD.**

(a) From July 1, 2019, to June 30, 2020, the commissioner shall engage in the expedited rulemaking process.

(b) From July 1, 2020, to June 30, 2021, the commissioner shall hire staff, develop forms, and communicate with stakeholders about the new assisted living licensing.

(c) From July 1, 2021, to June 30, 2022, all existing housing with services establishments with arranged home care providers must convert their registration and license to an assisted living license.

(d) After June 30, 2021, all new assisted living providers must be licensed by the commissioner.

(e) Beginning July 1, 2022, all assisted living providers must have a license issued by the commissioner.

Sec. 13. **RESIDENT QUALITY OF CARE AND OUTCOMES IMPROVEMENT TASK FORCE.**

The commissioner shall establish an expert task force to examine and make recommendations, on an ongoing basis, on how to apply proven safety and quality improvement practices and infrastructure to settings and providers that provide long-term services and supports. The task force shall include representation from nonprofit Minnesota-based organizations dedicated to patient safety and innovation in health care safety and quality, Department of Health staff with expertise in issues related to safety and adverse health events, consumer organizations, direct care providers or their representatives, organizations representing long-term care providers and home care providers in Minnesota, national patient safety experts, and other experts in the safety and quality improvement field. The task force shall have at least two public members who are either home care recipients in an assisted living setting or have family members living in assisted living settings, either past or present. The task force shall periodically provide recommendations to the commissioner and the legislature on changes needed to promote safety and quality improvement practices in long-term care settings and with long-term care providers. The membership shall be voluntary except that public members can be reimbursed under the provisions of Minnesota Statutes, section 15.059, subdivision 3. The task force will meet no fewer than four times per year. The task force must be established by July 1, 2020.

Sec. 14. **REPEALER.**

Minnesota Statutes 2018, sections 144G.01; 144G.02; 144G.03; 144G.04; 144G.05; and 144G.06, are repealed effective July 1, 2021.

ARTICLE 15

DEMENTIA CARE SERVICES FOR COMPREHENSIVE PLUS LICENSEES

Section 1. **[144I.12] DEFINITIONS.**

(a) For purposes of sections 144I.13 to 144I.18, the definitions in this section apply.

(b) "Advertise" means to make publicly and generally known, usually by printed notice, broadcast, verbal marketing, website, or electronic communication.

(c) "Alzheimer's disease" means a type of dementia that gradually destroys an individual's memory and ability to learn, reason, make judgments, communicate, and carry out daily activities.

(d) "Applicant" means the person, persons, or entity, required to complete an application for a comprehensive PLUS license. Applicant includes a sole proprietor, each partner in a partnership, and each member in a limited liability company, corporation, or entity that owns the assisted living facility. Applicant also includes the sole proprietor, each partner in a partnership, and each member in a limited liability company, corporation, or entity that operates the assisted living facility on behalf of the facility business owner.

(e) "Comprehensive PLUS" means the license described in section 144I.02, subdivision 2.

(f) "Dementia" means the loss of intellectual function of sufficient severity that interferes with an individual's daily functioning. Dementia affects an individual's memory and ability to think, reason, speak, and move. Symptoms may also include changes in personality, mood, and behavior. Irreversible dementias include but are not limited to:

(1) Alzheimer's disease;

(2) vascular dementia;

(3) Lewy body dementia;

(4) frontal-temporal lobe dementia;

(5) alcohol dementia;

(6) Huntington's disease; and

(7) Creutzfeldt-Jakob disease.

(g) "Dementia care unit" means a special care unit in a designated, separate area for individuals with Alzheimer's disease or other dementia that is locked, segregated, or secured to prevent or limit access by a resident outside the designated or separated area.

(h) "Dementia trained staff" means an employee that has completed the minimum training requirements and has demonstrated knowledge and understanding in supporting individuals with dementia.

(i) "Direct care staff" means a person employed by the assisted living facility whose primary responsibility is to provide personal care services to residents. These personal care services may include:

(1) medication administration;

(2) resident-focused activities;

(3) assistance with activities of daily living;

(4) supervision and support of residents; and

(5) serving meals, but not meal preparation.

(j) "Disclosure statement" means the written information the assisted living facility is required to provide to consumers to enhance the understanding of comprehensive PLUS services, costs, and operations.

(k) "Emergency situation" means a disruption to normal care and services caused by an unforeseen event beyond the control of the licensee whether natural, technological, or manmade where staff that are trained as required by adopted rules are not available.

(l) "Preservice training" means training that must be completed before staff takes responsibility for their job duties.

(m) "Resident" means an individual with dementia.

Sec. 2. **[144I.13] APPLICATION FOR COMPREHENSIVE PLUS LICENSE.**

Subdivision 1. **Comprehensive PLUS license required.** A licensed assisted living establishment that offers or provides care to residents with dementia in a dementia care unit must obtain a comprehensive PLUS license.

Subd. 2. **Application.** The applicant seeking a comprehensive PLUS license must submit to the commissioner a completed license application 60 days prior to receiving an initial license, the expiration of the current PLUS license, or a change in ownership.

Subd. 3. **Contents of application.** The applicant must also include the following with the initial application and fee:

(1) comprehensive PLUS uniform disclosure statement;

(2) employee training curricula;

(3) policies and procedures;

(4) floor plan;

(5) residency or admission agreement;

(6) copy of the service or care planning tool; and

(7) copies of brochures or advertisements that are used to advertise the facility and the facility's services.

Subd. 4. **Demonstrated capacity.** (a) The applicant must have the ability to provide services in a manner that is consistent with the requirements of this chapter.

(b) The commissioner shall consider the following criteria, including but not limited to:

(1) the experience of the applicant in managing residents with dementia or previous long-term care experience; and

(2) the compliance history of the applicant in the operation of any care facility licensed, certified, or registered under federal or state laws.

(c) If the applicant does not have experience in managing residents with dementia, the applicant must employ a consultant or management company for at least the first year of operation. The consultant or management company must have experience in dementia care operations and must be approved by the commissioner. The applicant must implement the recommendations of the consultant or management company or present an acceptable plan to the commissioner to address the consultant's identified concerns.

(d) The commissioner shall conduct an on-site inspection prior to the issuance of a comprehensive PLUS license to ensure compliance with the physical plant requirements.

(e) The label "Comprehensive PLUS" shall be identified on the license.

Subd. 5. **Relinquishing comprehensive PLUS license.** The licensee must notify the commissioner in writing at least 60 days prior to the voluntary relinquishment of the comprehensive PLUS license. For voluntary relinquishment, the facility must:

(1) give all residents and their designated representatives 45-day notice. The notice must include:

(i) the proposed effective date of the relinquishment;

(ii) changes in staffing;

(iii) changes in services including the elimination or addition of services; and

(iv) staff training that must occur when the relinquishment becomes effective;

(2) submit a transitional plan to the commissioner demonstrating how the current residents shall be evaluated and assessed to reside in other housing settings that are not an assisted

living facility with a comprehensive PLUS license, that are physically unsecured, or that would require move-out or transfer to other settings;

(3) change service or care plans as appropriate to address any needs the residents may have with the transition;

(4) notify the commissioner when the relinquishment process has been completed; and

(5) revise advertising materials and disclosure information to remove any reference that the facility is an assisted living establishment with a comprehensive PLUS license.

Sec. 3. **[144I.14] ADVERTISING OF COMPREHENSIVE PLUS LICENSE.**

Subdivision 1. **General.** An applicant may not advertise as having a comprehensive PLUS license until the applicant has obtained a comprehensive PLUS license from the commissioner. A prospective assisted living establishment seeking a comprehensive PLUS license may advertise that they have submitted an application for a license to the commissioner.

Subd. 2. **Advertising comprehensive PLUS license.** An assisted living establishment with a comprehensive PLUS license may advertise that it has a comprehensive PLUS license. However, the advertising materials may not imply or state that the commissioner recommends or supports a specific assisted living establishment with a comprehensive PLUS license.

Subd. 3. **Truth in advertising.** All advertising material must be truthful and must not include or use misleading information about the type or status of home care license connected to any housing with services establishment, including an assisted living establishment with a comprehensive PLUS license.

Subd. 4. **Notice of false advertising.** Upon the determination that a housing with services establishment inaccurately implies or advertises that they have a comprehensive PLUS license, the commissioner shall send a notice to the licensee to cease the advertising immediately. Failure to comply may result in a civil penalty as outlined in section 144I.21.

Sec. 4. **[144I.15] RESPONSIBILITIES OF ADMINISTRATION FOR COMPREHENSIVE PLUS LICENSEES.**

Subdivision 1. **General.** The comprehensive PLUS licensee is responsible for the care and housing of the persons with dementia and the provision of person-centered care that promotes each resident's dignity, independence, and comfort. This includes the supervision, training, and overall conduct of the staff.

Subd. 2. **Additional requirements.** (a) The comprehensive PLUS licensee must follow the comprehensive assisted living license requirements in section 144I.02, home care licensing under chapter 144A, and the criteria in this section.

(b) The administrator of the assisted living establishment with a comprehensive PLUS license must complete and document that at least ten hours of the required annual continuing educational requirements relate to the care of individuals with dementia. Continuing education credits must be obtained through commissioner-approved sources that may include college courses, preceptor credits, self-directed activities, course instructor credits, corporate training, in-service training, professional association training, web-based training, correspondence courses, telecourses, seminars, and workshops.

(c) The comprehensive PLUS licensee must provide a uniform disclosure statement designated by the commissioner to each person who requests information that explains the services, costs, and operations for a resident at an assisted living establishment with a comprehensive PLUS license.

Subd. 3. **Policies.** In addition to the policies and procedures required in the licensing of home care services in chapter 144A, the comprehensive PLUS licensee must develop and implement policies and procedures that address the:

(1) philosophy of how services are provided based upon the assisted living licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented;

(2) evaluation of behavioral symptoms and design of supports for intervention plans;

(3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes;

(4) assessment of residents for the use and effects of medications, including psychotropic medications;

(5) use of supportive devices with restraining qualities;

(6) staffing plan to ensure that residents' needs are met including a quality control system that periodically reviews how well the staffing plan is working;

(7) staff training specific to dementia care;

(8) description of life enrichment programs and how activities are implemented;

(9) description of family support programs and efforts to keep the family engaged;

(10) limiting the use of public address and intercom systems for emergencies and evacuation drills only;

(11) transportation coordination and assistance to and from outside medical appointments; and

(12) safekeeping of resident's possessions.

The policies and procedures must be provided to residents and the resident's representative at the time of move-in.

Sec. 5. **[144I.16] STAFFING AND STAFF TRAINING FOR COMPREHENSIVE PLUS LICENSEES.**

Subdivision 1. **General.** (a) The comprehensive PLUS licensee must provide residents with dementia-trained staff who have been instructed in the person-centered care approach. All direct care and other community staff assigned to care for dementia residents must be specially trained to work with residents with Alzheimer's disease and other dementias.

(b) Only staff trained as specified in subdivisions 2 and 3 shall be assigned to care for dementia residents.

(c) Staffing levels must be sufficient to meet the scheduled and unscheduled needs of residents. Staffing levels during nighttime hours shall be based on the sleep patterns and needs of residents.

(d) In an emergency situation when trained staff are not available to provide services, the assisted living facility may assign staff who have not completed the required training. The particular emergency situation must be documented and must address:

(1) the nature of the emergency;

(2) how long the emergency lasted; and

(3) the names and positions of staff that provided coverage.

Subd. 2. **Staffing requirements.** A comprehensive PLUS licensee must ensure that staff who provide support to residents with dementia have a basic understanding and fundamental knowledge of the residents' emotional and unique health care needs using person-centered planning delivery. Direct care dementia-trained staff and other staff must be trained on the topics identified during the expedited rulemaking process. These requirements are in addition to the licensing requirements for training.

Subd. 3. **Supervising staff training.** Persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia.

Subd. 4. **Preservice and in-service training.** Preservice and in-service training may include various methods of instruction, such as classroom style, web-based training, video, or one-to-one training. The dementia care unit must have a method for determining and documenting each staff person's knowledge and understanding of the training provided. All training must be documented.

Sec. 6. **[144I.17] SERVICES FOR RESIDENTS WITH DEMENTIA.**

Subdivision 1. **Move-in assessment.** (a) At the time of move-in, dementia-trained staff must make reasonable attempts to identify the customary routines of each resident and the resident's preferences in how services may be delivered. Minimum services to be provided include:

(1) assistance with activities of daily living that address the needs of each resident with dementia due to cognitive or physical limitations. These services must meet or be in addition to the requirements in the licensing rules for the facility. Services must be provided in a person-centered manner that promotes resident choice, dignity, and sustains the resident's abilities;

(2) health care services provided according to the licensing statutes and rules of the facility;

(3) a daily meal program for nutrition and hydration must be provided and available throughout each resident's waking hours. The individualized nutritional plan for each resident must be documented in the resident's service or care plan. In addition, the assisted living must:

(i) provide visual contrast between plates, eating utensils, and the table to maximize the independence of each resident; and

(ii) provide adaptive eating utensils for those residents who have been evaluated as needing them to maintain their eating skills; and

(4) meaningful activities that promote or help sustain the physical and emotional well-being of residents. The activities must be person-directed and available during residents' waking hours.

(b) Each resident must be evaluated for activities according to the licensing rules governing assisted living. In addition, the evaluation must address the following:

(1) past and current interests;

(2) current abilities and skills;

(3) emotional and social needs and patterns;

(4) physical abilities and limitations;

(5) adaptations necessary for the resident to participate; and

(6) identification of activities for behavioral interventions.

(c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs.

(d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to:

(1) occupation or chore related tasks;

(2) scheduled and planned events such as entertainment or outings;

(3) spontaneous activities for enjoyment or those that may help defuse a behavior;

(4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music;

(5) spiritual, creative, and intellectual activities;

(6) sensory stimulation activities;

(7) physical activities that enhance or maintain a resident's ability to ambulate or move; and

(8) outdoor activities.

(e) Behavioral symptoms that negatively impact the resident and others in the assisted living must be evaluated and included on the service or care plan. The staff must initiate and coordinate outside consultation or acute care when indicated.

(f) Support must be offered to family and other significant relationships on a regularly scheduled basis but not less than quarterly. Examples in which support may be provided include support groups, community gatherings, social events, or meetings that address the needs of individual residents or their family or significant relationships.

(g) Access to secured outdoor space and walkways that allow residents to enter and return without staff assistance must be provided.

Sec. 7. **[144I.18] PHYSICAL DESIGN, ENVIRONMENT, AND SAFETY OF DEMENTIA CARE UNITS.**

Subdivision 1. **Life safety code.** A comprehensive PLUS licensee must comply with the most current edition of NFPA.101, life safety code, health care chapter.

Subd. 2. **Comprehensive PLUS and dementia care units located on ground level.** Dementia care units must be located on the ground level of the building to ensure access to outdoor space and safe evacuation.

Subd. 3. **Secure outdoor recreation area.** The assisted living establishment with a comprehensive PLUS license must provide:

(1) outdoor recreation space that is a minimum of 600 square feet or 15 square feet per resident, whichever is greater, and is exclusive of normal walkways and landscaping. The space must have a minimum dimension of 15 feet in any direction;

(2) fences surrounding the perimeter of the outdoor recreation area must be no less than six feet in height, constructed to reduce the risk of resident elopement, and maintained in functional condition;

(3) walkways must meet applicable federal, state, and accessibility codes. Walkway surfaces must be of a medium to dark reflectance value to prevent glare from reflected sunlight;

(4) outdoor furniture must be of a sufficient weight, stability, and design, and be maintained to prevent resident injury or prevent aid in elopement; and

(5) doors to the outdoor recreation area may be locked during nighttime hours or during severe weather per facility policy.

Subd. 4. **Common areas in dementia care unit.** (a) Common areas must include the following requirements:

(1) freedom of movement for the residents to common areas and to the resident's personal spaces;

(2) a multipurpose room for dining, group and individual activities, and family visits that complies with the facility licensing requirements for common space;

(3) comfortable seating;

(4) safe corridors and passageways through the common areas that are free of objects that may cause falls; and

(5) windows or skylights that are at least as large as 12 percent of the square footage of the common area.

(b) A public address or intercom system is not required, however if one exists it must be used within the dementia care unit only for emergencies.

Subd. 5. **Resident rooms in dementia care unit.** (a) Residents may not be locked out of or inside of their rooms at any time.

(b) Residents must be encouraged to decorate and furnish their rooms with personal items and furnishings based on the resident's needs, preferences, and appropriateness.

(c) The dementia care unit must individually identify residents' rooms to assist residents in recognizing their room.

ARTICLE 16
DECEPTIVE MARKETING AND BUSINESS PRACTICES

Section 1. **[144I.20] DEFINITIONS.**

Subdivision 1. **Applicability.** For the purposes of this section and section 144I.21, the definitions in this section have the meanings given.

Subd. 2. **Facility.** "Facility" means a facility that is licensed as a nursing home under chapter 144A or a boarding care home under sections 144.50 to 144.56; a registered housing with services establishment under chapter 144D; the licensed home care provider providing services in a housing with services establishment; or an assisted living licensed under this chapter.

Subd. 3. **Resident representative.** "Resident representative" means a court-appointed guardian, health care agent under section 145C.01, subdivision 2, or person chosen by the resident and identified in the resident's records on file with the facility.

Sec. 2. **[144I.21] DECEPTIVE MARKETING AND BUSINESS PRACTICES.**

(a) Facilities are prohibited from engaging in deceptive marketing and business practices as follows:

(1) making any false, fraudulent, deceptive, or misleading statements in marketing, advertising, or other oral or written description or representation of cares or services, whether in oral, written, or electronic form;

(2) arranging for or providing health or supportive care services that are substantially different from or more expensive than those offered, promised, marketed, or advertised;

(3) failing to deliver any health or supportive care or services the provider or facility promised or represented that the facility was able to provide;

(4) failing to inform the resident in writing of any limitations to services available prior to executing a contract for a service plan or lease agreement;

(5) discharging or terminating the lease or services of a resident following a required period of private pay when the next form of payment will be from the medical assistance waivers under sections 256B.0915 and 256B.49 after the licensee has promised to continue the same services after private pay ceases;

(6) discharging or terminating the lease or services of a resident following a required period of private pay when the next form of payment will be from the medical assistance elderly waiver program after the licensee has promised to continue the same services after private pay ceases;

(7) failing to disclose and clearly explain the purpose of any nonrefundable fee prior to executing a contract for the service plan or lease;

(8) advertising or representing orally or in writing that the licensee has a special care unit, such as for dementia or memory care, without complying with training and disclosure requirements under sections 144D.065 and 325F.72 and any other applicable law; and

(9) misstating or falsely asserting statutory requirements as being the cause of a business decision.

(b) A violation of this section shall result in no less than a level 2 fine, but may result in a level 3 or level 4 fine if, as a result of the deceptive marketing and business practices, the resulting harm was equal to or greater than that described in section 144A.47, subdivision 11.

(c) The commissioner may suspend, refuse to renew, or revoke a license or provisional license for a repeated violation of this section.

EFFECTIVE DATE. This section is effective the day following final enactment.

ARTICLE 17
HOUSING WITH SERVICES CONFORMING CHANGES

Section 1. Minnesota Statutes 2018, section 144D.01, subdivision 4, is amended to read:

Subd. 4. **Housing with services establishment or establishment.** (a) "Housing with services establishment" or "establishment" means:

(1) an establishment providing sleeping accommodations to one or more adult residents, at least 80 percent of which are 55 years of age or older, and offering or providing, for a fee, ~~one or more regularly scheduled health-related services or~~ two or more regularly scheduled supportive services, whether offered or provided directly by the establishment or by another entity arranged for by the establishment; or

(2) an establishment that registers under section 144D.025.

(b) Housing with services establishment does not include:

(1) a nursing home licensed under chapter 144A;

(2) a hospital, certified boarding care home, or supervised living facility licensed under sections 144.50 to 144.56;

(3) a board and lodging establishment licensed under chapter 157 and Minnesota Rules, parts 9520.0500 to 9520.0670, or under chapter 245D or 245G;

(4) an assisted living licensed under chapter 144I;

~~(4)~~ (5) a board and lodging establishment which serves as a shelter for battered women or other similar purpose;

~~(5)~~ (6) a family adult foster care home licensed by the Department of Human Services;

~~(6)~~ (7) private homes in which the residents are related by kinship, law, or affinity with the providers of services;

~~(7)~~ (8) residential settings for persons with developmental disabilities in which the services are licensed under chapter 245D;

~~(8)~~ (9) a home-sharing arrangement such as when an elderly or disabled person or single-parent family makes lodging in a private residence available to another person in exchange for services or rent, or both;

~~(9)~~ (10) a duly organized condominium, cooperative, common interest community, or owners' association of the foregoing where at least 80 percent of the units that comprise the condominium, cooperative, or common interest community are occupied by individuals who are the owners, members, or shareholders of the units;

~~(10)~~ (11) services for persons with developmental disabilities that are provided under a license under chapter 245D; or

~~(11)~~ (12) a temporary family health care dwelling as defined in sections 394.307 and 462.3593.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 2. Minnesota Statutes 2018, section 144D.015, is amended to read:

144D.015 DEFINITION FOR PURPOSES OF LONG-TERM CARE INSURANCE.

For purposes of consistency with terminology commonly used in long-term care insurance policies and notwithstanding chapter 144G, a housing with services establishment that is registered under section 144D.03 and that holds, or makes arrangements with an individual or entity that holds any type of home care license and all other licenses, permits, registrations, or other governmental approvals legally required for delivery of the services the establishment offers or provides to its residents, constitutes an "assisted living facility" or "assisted living residence." A housing with services that provides home care services must be licensed as an assisted living pursuant to chapter 144I.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 3. Minnesota Statutes 2018, section 144D.04, subdivision 2, is amended to read:

Subd. 2. **Contents of contract.** A housing with services contract, which need not be entitled as such to comply with this section, shall include at least the following elements in itself or through supporting documents or attachments:

(1) the name, street address, and mailing address of the establishment;

(2) the name and mailing address of the owner or owners of the establishment and, if the owner or owners is not a natural person, identification of the type of business entity of the owner or owners;

(3) the name and mailing address of the managing agent, through management agreement or lease agreement, of the establishment, if different from the owner or owners;

(4) the name and address of at least one natural person who is authorized to accept service of process on behalf of the owner or owners and managing agent;

(5) a statement describing the registration and licensure status of the establishment and any provider providing health-related or supportive services under an arrangement with the establishment;

(6) the term of the contract;

(7) a description of the services to be provided to the resident in the base rate to be paid by the resident, including a delineation of the portion of the base rate that constitutes rent and a delineation of charges for each service included in the base rate;

(8) a description of any additional services, ~~including home care services,~~ available for an additional fee from the establishment directly or through arrangements with the establishment, and a schedule of fees charged for these services;

(9) a conspicuous notice informing the tenant of the policy concerning the conditions under which and the process through which the contract may be modified, amended, or terminated, including whether a move to a different room or sharing a room would be required in the event that the tenant can no longer pay the current rent;

(10) a description of the establishment's complaint resolution process available to residents including the toll-free complaint line for the Office of Ombudsman for Long-Term Care;

(11) the resident's designated representative, if any;

(12) the establishment's referral procedures if the contract is terminated;

(13) requirements of residency used by the establishment to determine who may reside or continue to reside in the housing with services establishment;

(14) billing and payment procedures and requirements;

(15) a statement regarding the ability of a resident to receive services from service providers with whom the establishment does not have an arrangement;

(16) a statement regarding the availability of public funds for payment for residence or services in the establishment; and

(17) a statement regarding the availability of and contact information for long-term care consultation services under section 256B.0911 in the county in which the establishment is located.

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 4. **REPEALER.**

Minnesota Statutes 2018, sections 144D.01, subdivisions 2a, 3a, and 6; 144D.04, subdivision 2a; 144D.045; 144D.06; 144D.09; and 144D.10, are repealed effective July 1, 2022.

ARTICLE 18

HOME CARE CHANGES

Section 1. Minnesota Statutes 2018, section 144A.43, subdivision 6, is amended to read:

Subd. 6. **License.** "License" means a basic or comprehensive home care license issued by the commissioner to a home care provider and effective July 1, 2022, providing services outside of assisted living settings licensed under chapter 144I.

Sec. 2. **[144A.431] APPLICABILITY OF HOME CARE STATUTES TO ASSISTED LIVING LICENSE REQUIREMENTS IN CHAPTER 144I.**

The provisions in sections 144A.43 to 144A.47 apply to assisted living license requirements pursuant to section 144I.02. Assisted living license requirements in chapter 144I are effective starting July 1, 2021, for all new assisted living licensees and when home care licensees have converted their home care license to the assisted living license between July 1, 2021, and June 30, 2022.

Sec. 3. Minnesota Statutes 2018, section 144A.44, subdivision 1, is amended to read:

Subdivision 1. **Statement of rights.** (a) A ~~person~~ client or resident who receives home care services in the community or in an assisted living licensed under chapter 144I has these rights:

(1) ~~the right to~~ receive written information, in plain language, about rights before receiving services, including what to do if rights are violated;

(2) ~~the right to~~ receive care and services according to a suitable and up-to-date plan, and subject to accepted health care, medical or nursing standards and person-centered care, to take an active part in developing, modifying, and evaluating the plan and services;

(3) ~~the right to~~ be told before receiving services the type and disciplines of staff who will be providing the services, the frequency of visits proposed to be furnished, other choices that are available for addressing home care needs, and the potential consequences of refusing these services;

(4) ~~the right to~~ be told in advance of any recommended changes by the provider in the service plan and to take an active part in any decisions about changes to the service plan;

(5) ~~the right to~~ refuse services or treatment;

(6) ~~the right to~~ know, before receiving services or during the initial visit, any limits to the services available from a home care provider;

(7) ~~the right to~~ be told before services are initiated what the provider charges for the services; to what extent payment may be expected from health insurance, public programs, or other sources, if known; and what charges the client may be responsible for paying;

(8) ~~the right to~~ know that there may be other services available in the community, including other home care services and providers, and to know where to find information about these services;

(9) ~~the right to~~ choose freely among available providers and to change providers after services have begun, within the limits of health insurance, long-term care insurance, medical assistance, ~~or~~ other health programs, or public programs;

(10) ~~the right to~~ have personal, financial, and medical information kept private, and to be advised of the provider's policies and procedures regarding disclosure of such information;

(11) ~~the right to~~ access the client's own records and written information from those records in accordance with sections 144.291 to 144.298;

(12) ~~the right to~~ be served by people who are properly trained and competent to perform their duties;

(13) ~~the right to~~ be treated with courtesy and respect, and to have the client's property treated with respect;

(14) ~~the right to~~ be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act;

(15) ~~the right to~~ reasonable, advance notice of changes in services or charges;

(16) ~~the right to~~ know the provider's reason for termination of services;

(17) ~~the right to~~ at least ~~ten~~ 30 days' advance notice of the termination of a service or housing by a provider, except in cases where:

(i) the client engages in conduct that significantly alters the terms of the service plan with the home care provider;

(ii) the client, person who lives with the client, or others create an abusive or unsafe work environment for the person providing home care services; or

(iii) an emergency or a significant change in the client's condition has resulted in service needs that exceed the current service plan and that cannot be safely met by the home care provider;

(18) ~~the right to~~ a coordinated transfer when there will be a change in the provider of services;

(19) ~~the right to~~ complain to staff and others of the client's choice about services that are provided, or fail to be provided, and the lack of courtesy or respect to the client or the client's property and the right to recommend changes in policies and services, free from retaliation including the threat of termination of services;

(20) ~~the right to~~ know how to contact an individual associated with the home care provider who is responsible for handling problems and to have the home care provider investigate and attempt to resolve the grievance or complaint;

(21) ~~the right to~~ know the name and address of the state or county agency to contact for additional information or assistance; ~~and~~

(22) ~~the right to~~ assert these rights personally, or have them asserted by the client's representative or by anyone on behalf of the client, without retaliation~~.~~;

(23) internet service at the client's own expense, unless it is provided by the provider; and

(24) place an electronic monitoring device in the client's or resident's space in compliance with state requirements.

(b) When providers violate the rights in this section, they are subject to the fines and license actions in sections 144A.474, subdivision 11, and 144A.475.

(c) Providers must do all of the following:

(1) encourage and assist in the fullest possible exercise of these rights;

(2) provide the names and telephone numbers of individuals and organizations that provide advocacy and legal services for clients and residents seeking to assert their rights;

(3) make every effort to assist clients or residents in obtaining information regarding whether Medicare, medical assistance, other health programs, or public programs will pay for services;

(4) make reasonable accommodations for people who have communication disabilities, or those who speak a language other than English; and

(5) provide all information and notices in plain language and in terms the client or resident can understand.

Sec. 4. Minnesota Statutes 2018, section 144A.44, subdivision 2, is amended to read:

Subd. 2. **Interpretation and enforcement of rights.** These rights are established for the benefit of clients or residents who receive home care services. All home care providers, including those exempted under section 144A.471, must comply with this section. The commissioner shall enforce this section and the home care bill of rights requirement against home care providers exempt from licensure in the same manner as for licensees. A home care provider may not request or require a client to surrender any of these rights as a condition of receiving services. This statement of rights does not replace or diminish other rights and liberties that may exist relative to clients receiving home care services, persons providing home care services, or providers licensed under sections 144A.43 to 144A.482.

Sec. 5. Minnesota Statutes 2018, section 144A.441, is amended to read:

144A.441 ASSISTED LIVING BILL OF RIGHTS ADDENDUM.

Assisted living ~~clients~~ residents, as defined in section ~~144G.01, subdivision 3~~ 144I.01, shall be provided with the home care bill of rights required by section 144A.44, except that the home care bill of rights provided to these ~~clients~~ residents must include the following provision in place of the provision in section 144A.44, subdivision 1, paragraph (a), clause (17):

"(17) the right to reasonable, advance notice of changes in services or charges, including at least 30 days' advance notice of the termination of a service or housing by a provider, except in cases where:

(i) the recipient of services engages in conduct that alters the conditions of employment as specified in the employment contract between the home care provider and the individual providing home care services, or creates an abusive or unsafe work environment for the individual providing home care services;

(ii) an emergency for the informal caregiver or a significant change in the recipient's condition has resulted in service needs that exceed the current service provider agreement and that cannot be safely met by the home care provider; or

(iii) the provider has not received payment for services~~, for which at least ten days' advance notice of the termination of a service shall be provided~~."

Sec. 6. Minnesota Statutes 2018, section 144A.442, is amended to read:

144A.442 ASSISTED LIVING ~~CLIENTS~~ RESIDENTS; SERVICE TERMINATION.

(a) If an arranged home care provider, as defined in section 144D.01, subdivision 2a, who is not also Medicare certified terminates a service agreement or service plan with an assisted living client, as defined in section 144G.01, subdivision 3, the home care provider shall provide the assisted living client and the legal or designated representatives of the client, if any, with a written notice of termination which includes the following information:

(1) the effective date of termination;

(2) the reason for termination;

(3) without extending the termination notice period, an affirmative offer to meet with the assisted living client or client representatives within no more than five business days of the date of the termination notice to discuss the termination;

(4) contact information for a reasonable number of other home care providers in the geographic area of the assisted living client, as required by section 144A.4791, subdivision 10;

(5) a statement that the provider will participate in a coordinated transfer of the care of the client to another provider or caregiver, as required by section 144A.44, subdivision 1, clause (18);

(6) the name and contact information of a representative of the home care provider with whom the client may discuss the notice of termination;

(7) a copy of the home care bill of rights; and

(8) a statement that the notice of termination of home care services by the home care provider does not constitute notice of termination of the housing with services contract with a housing with services establishment.

(b) Effective July 1, 2021, all assisted living settings must comply with the provisions in chapter 144I relating to termination of services and housing.

Sec. 7. Minnesota Statutes 2018, section 144A.471, subdivision 1, is amended to read:

Subdivision 1. **License required.** (a) A home care provider may not open, operate, manage, conduct, maintain, or advertise itself as a home care provider or provide home care

services in Minnesota without a temporary or current home care provider license issued by the commissioner of health.

(b) Effective July 1, 2021, all assisted living providers licensed pursuant to chapter 144I shall comply with this chapter for the provision of basic and comprehensive home care services.

Sec. 8. Minnesota Statutes 2018, section 144A.471, subdivision 5, is amended to read:

Subd. 5. **Basic and comprehensive levels of licensure.** (a) An applicant seeking to become a home care provider must apply for either a basic or comprehensive home care license.

(b) Effective July 1, 2021, all home care providers who also provide housing, must apply for an assisted living license pursuant to chapter 144I according to the process set out by the commissioner. Home care providers providing services in the community without providing housing must apply for a license under this chapter.

Sec. 9. Minnesota Statutes 2018, section 144A.471, subdivision 9, is amended to read:

Subd. 9. **Exclusions from home care licensure.** The following are excluded from home care licensure and are not required to provide the home care bill of rights:

(1) an individual or business entity providing only coordination of home care that includes one or more of the following:

(i) determination of whether a client needs home care services, or assisting a client in determining what services are needed;

(ii) referral of clients to a home care provider;

(iii) administration of payments for home care services; or

(iv) administration of a health care home established under section 256B.0751;

(2) an individual who is not an employee of a licensed home care provider if the individual:

(i) only provides services as an independent contractor to one or more licensed home care providers;

(ii) provides no services under direct agreements or contracts with clients; and

(iii) is contractually bound to perform services in compliance with the contracting home care provider's policies and service plans;

(3) a business that provides staff to home care providers, such as a temporary employment agency, if the business:

(i) only provides staff under contract to licensed or exempt providers;

(ii) provides no services under direct agreements with clients; and

(iii) is contractually bound to perform services under the contracting home care provider's direction and supervision;

(4) any home care services conducted by and for the adherents of any recognized church or religious denomination for its members through spiritual means, or by prayer for healing;

(5) an individual who only provides home care services to a relative;

(6) an individual not connected with a home care provider that provides assistance with basic home care needs if the assistance is provided primarily as a contribution and not as a business;

(7) an individual not connected with a home care provider that shares housing with and provides primarily housekeeping or homemaking services to an elderly or disabled person in return for free or reduced-cost housing;

(8) an individual or provider providing home-delivered meal services;

(9) an individual providing senior companion services and other older American volunteer programs (OAVP) established under the Domestic Volunteer Service Act of 1973, United States Code, title 42, chapter 66;

~~(10) an employee of a nursing home or home care provider licensed under this chapter or an employee of a boarding care home licensed under sections 144.50 to 144.56 when responding to occasional emergency calls from individuals residing in a residential setting that is attached to or located on property contiguous to the nursing home, boarding care home, or location where home care services are also provided;~~

~~(11) an employee of a nursing home or home care provider licensed under this chapter or an employee of a boarding care home licensed under sections 144.50 to 144.56 when providing occasional minor services free of charge to individuals residing in a residential setting that is attached to or located on property contiguous to the nursing home, boarding care home, or location where home care services are also provided;~~

(12) a member of a professional corporation organized under chapter 319B that does not regularly offer or provide home care services as defined in section 144A.43, subdivision 3;

(13) the following organizations established to provide medical or surgical services that do not regularly offer or provide home care services as defined in section 144A.43, subdivision 3: a business trust organized under sections 318.01 to 318.04, a nonprofit corporation organized under chapter 317A, a partnership organized under chapter 323, or any other entity determined by the commissioner;

(14) an individual or agency that provides medical supplies or durable medical equipment, except when the provision of supplies or equipment is accompanied by a home care service;

(15) a physician licensed under chapter 147;

(16) an individual who provides home care services to a person with a developmental disability who lives in a place of residence with a family, foster family, or primary caregiver;

(17) a business that only provides services that are primarily instructional and not medical services or health-related support services;

(18) an individual who performs basic home care services for no more than 14 hours each calendar week to no more than one client;

(19) an individual or business licensed as hospice as defined in sections 144A.75 to 144A.755 who is not providing home care services independent of hospice service;

(20) activities conducted by the commissioner of health or a community health board as defined in section 145A.02, subdivision 5, including communicable disease investigations or testing; or

(21) administering or monitoring a prescribed therapy necessary to control or prevent a communicable disease, or the monitoring of an individual's compliance with a health directive as defined in section 144.4172, subdivision 6.

EFFECTIVE DATE. The amendments to clauses (10) and (11) are effective July 1, 2021.

Sec. 10. Minnesota Statutes 2018, section 144A.472, subdivision 7, is amended to read:

Subd. 7. **Fees; application, change of ownership, and renewal.** (a) An initial applicant seeking temporary home care licensure must submit the following application fee to the commissioner along with a completed application:

(1) for a basic home care provider, $2,100; or

(2) for a comprehensive home care provider, $4,200.

(b) A home care provider who is filing a change of ownership as required under subdivision 5 must submit the following application fee to the commissioner, along with the documentation required for the change of ownership:

(1) for a basic home care provider, $2,100; or

(2) for a comprehensive home care provider, $4,200.

(c) For the period ending June 30, 2018, a home care provider who is seeking to renew the provider's license shall pay a fee to the commissioner based on revenues derived from the provision of home care services during the calendar year prior to the year in which the application is submitted, according to the following schedule:

License Renewal Fee

Provider Annual Revenue	**Fee**
greater than $1,500,000	$6,625
greater than $1,275,000 and no more than $1,500,000	$5,797
greater than $1,100,000 and no more than $1,275,000	$4,969
greater than $950,000 and no more than $1,100,000	$4,141
greater than $850,000 and no more than $950,000	$3,727
greater than $750,000 and no more than $850,000	$3,313
greater than $650,000 and no more than $750,000	$2,898
greater than $550,000 and no more than $650,000	$2,485
greater than $450,000 and no more than $550,000	$2,070
greater than $350,000 and no more than $450,000	$1,656
greater than $250,000 and no more than $350,000	$1,242
greater than $100,000 and no more than $250,000	$828
greater than $50,000 and no more than $100,000	$500
greater than $25,000 and no more than $50,000	$400
no more than $25,000	$200

(d) For the period between July 1, 2018, and June 30, 2020, a home care provider who is seeking to renew the provider's license shall pay a fee to the commissioner in an amount that is ten percent higher than the applicable fee in paragraph (c). A home care provider's fee shall be based on revenues derived from the provision of home care services during the calendar year prior to the year in which the application is submitted.

(e) Beginning July 1, 2020, a home care provider who is seeking to renew the provider's license shall pay a fee to the commissioner based on revenues derived from the provision

of home care services during the calendar year prior to the year in which the application is submitted, according to the following schedule:

License Renewal Fee

Provider Annual Revenue	**Fee**
greater than $1,500,000	$7,651
greater than $1,275,000 and no more than $1,500,000	$6,695
greater than $1,100,000 and no more than $1,275,000	$5,739
greater than $950,000 and no more than $1,100,000	$4,783
greater than $850,000 and no more than $950,000	$4,304
greater than $750,000 and no more than $850,000	$3,826
greater than $650,000 and no more than $750,000	$3,347
greater than $550,000 and no more than $650,000	$2,870
greater than $450,000 and no more than $550,000	$2,391
greater than $350,000 and no more than $450,000	$1,913
greater than $250,000 and no more than $350,000	$1,434
greater than $100,000 and no more than $250,000	$957
greater than $50,000 and no more than $100,000	$577
greater than $25,000 and no more than $50,000	$462
no more than $25,000	$231

(f) If requested, the home care provider shall provide the commissioner information to verify the provider's annual revenues or other information as needed, including copies of documents submitted to the Department of Revenue.

(g) At each annual renewal, a home care provider may elect to pay the highest renewal fee for its license category, and not provide annual revenue information to the commissioner.

(h) A temporary license or license applicant, or temporary licensee or licensee that knowingly provides the commissioner incorrect revenue amounts for the purpose of paying a lower license fee, shall be subject to a civil penalty in the amount of double the fee the provider should have paid.

(i) The fee for failure to comply with the notification requirements in section 144A.473, subdivision 2, paragraph (c), is $1,000.

~~(i)~~ (j) Fees ~~and penalties~~ collected under this section shall be deposited in the state treasury and credited to the state government special revenue fund. All fees are nonrefundable. Fees collected under paragraphs (c), (d), and (e) are nonrefundable even if

received before July 1, 2017, for temporary licenses or licenses being issued effective July 1, 2017, or later.

(k) Fines collected under this subdivision shall be deposited in a dedicated special revenue account. On an annual basis, the balance in the special revenue account will be appropriated to the commissioner to implement the recommendations of the advisory council established in section 144A.4799. Fines collected in state fiscal years 2018 and 2019 shall be deposited in the dedicated special revenue account as described in this section.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 11. Minnesota Statutes 2018, section 144A.474, subdivision 9, is amended to read:

Subd. 9. **Follow-up surveys.** For providers that have Level 3 or Level 4 violations under subdivision 11, or any violations determined to be widespread, the department shall conduct a follow-up survey within 90 calendar days of the survey. When conducting a follow-up survey, the surveyor will focus on whether the previous violations have been corrected and may also address any new violations that are observed while evaluating the corrections that have been made. ~~If a new violation is identified on a follow-up survey, no fine will be imposed unless it is not corrected on the next follow-up survey.~~

Sec. 12. Minnesota Statutes 2018, section 144A.474, subdivision 11, is amended to read:

Subd. 11. **Fines.** (a) Fines and enforcement actions under this subdivision may be assessed based on the level and scope of the violations described in paragraph ~~(c)~~ (b) and imposed immediately with no opportunity to correct the violation first as follows:

(1) Level 1, no fines or enforcement;

(2) Level 2, ~~fines ranging from $0 to~~ a fine of $500 per violation, in addition to any of the enforcement mechanisms authorized in section 144A.475 for widespread violations;

(3) Level 3, ~~fines ranging from $500 to $1,000~~ a fine of $3,000 per incident plus $100 for each resident affected by the violation, in addition to any of the enforcement mechanisms authorized in section 144A.475; ~~and~~

(4) Level 4, ~~fines ranging from $1,000 to~~ a fine of $5,000 per incident plus $200 for each resident affected by the violation, in addition to any of the enforcement mechanisms authorized in section 144A.475~~.~~;

(5) for maltreatment violations as defined in section 626.557 including abuse, neglect, financial exploitation, and drug diversion, that are determined against the provider, an

immediate fine shall be imposed of $5,000 per incident plus $200 for each resident affected by the violation; and

(6) the fines in clauses (1) to (4) are increased and immediate fine imposition is authorized for both surveys and investigations conducted.

(b) Correction orders for violations are categorized by both level and scope and fines shall be assessed as follows:

(1) level of violation:

(i) Level 1 is a violation that has no potential to cause more than a minimal impact on the client and does not affect health or safety;

(ii) Level 2 is a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death;

(iii) Level 3 is a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death; and

(iv) Level 4 is a violation that results in serious injury, impairment, or death;

(2) scope of violation:

(i) isolated, when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally;

(ii) pattern, when more than a limited number of clients are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly but is not found to be pervasive; and

(iii) widespread, when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the clients.

(c) If the commissioner finds that the applicant or a home care provider ~~required to be licensed under sections 144A.43 to 144A.482~~ has not corrected violations by the date specified in the correction order or conditional license resulting from a survey or complaint investigation, the commissioner ~~may impose a fine. A~~ shall provide a notice of noncompliance with a correction order ~~must be mailed~~ by e-mail to the applicant's or provider's last known e-mail address. The noncompliance notice must list the violations not corrected.

(d) For every violation identified by the commissioner, the commissioner shall issue an immediate fine pursuant to paragraph (a), clause (6). The license holder must still correct the violation in the time specified. The issuance of an immediate fine can occur in addition to any enforcement mechanism authorized under section 144A.475. The immediate fine may be appealed as allowed under this subdivision.

~~(d)~~ (e) The license holder must pay the fines assessed on or before the payment date specified. If the license holder fails to fully comply with the order, the commissioner may issue a second fine or suspend the license until the license holder complies by paying the fine. A timely appeal shall stay payment of the fine until the commissioner issues a final order.

~~(e)~~ (f) A license holder shall promptly notify the commissioner in writing when a violation specified in the order is corrected. If upon reinspection the commissioner determines that a violation has not been corrected as indicated by the order, the commissioner may issue a second fine. The commissioner shall notify the license holder by mail to the last known address in the licensing record that a second fine has been assessed. The license holder may appeal the second fine as provided under this subdivision.

~~(f)~~ (g) A home care provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14.

~~(g)~~ (h) When a fine has been assessed, the license holder may not avoid payment by closing, selling, or otherwise transferring the licensed program to a third party. In such an event, the license holder shall be liable for payment of the fine.

~~(h)~~ (i) In addition to any fine imposed under this section, the commissioner may assess a penalty amount based on costs related to an investigation that results in a final order assessing a fine or other enforcement action authorized by this chapter.

~~(i)~~ (j) Fines collected under this subdivision shall be deposited in ~~the state government~~ a dedicated special revenue ~~fund and credited to an account separate from the revenue collected under section 144A.472. Subject to an appropriation by the legislature, the revenue from the fines collected must be used by the commissioner for special projects to improve home care in Minnesota as recommended by~~ account. On an annual basis, the balance in the special revenue account shall be appropriated to the commissioner to implement the recommendations of the advisory council established in section 144A.4799. Fines collected in state fiscal years 2018 and 2019 shall be deposited in the dedicated special revenue account as described in this section.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 13. Minnesota Statutes 2018, section 144A.475, subdivision 3b, is amended to read:

Subd. 3b. **Expedited hearing.** (a) Within five business days of receipt of the license holder's timely appeal of a temporary suspension or issuance of a conditional license, the commissioner shall request assignment of an administrative law judge. The request must include a proposed date, time, and place of a hearing. A hearing must be conducted by an administrative law judge pursuant to Minnesota Rules, parts 1400.8505 to 1400.8612, within 30 calendar days of the request for assignment, unless an extension is requested by either party and granted by the administrative law judge for good cause. The commissioner shall issue a notice of hearing by certified mail or personal service at least ten business days before the hearing. Certified mail to the last known address is sufficient. The scope of the hearing shall be limited solely to the issue of whether the temporary suspension or issuance of a conditional license should remain in effect and whether there is sufficient evidence to conclude that the licensee's actions or failure to comply with applicable laws are level 3 or 4 violations as defined in section 144A.474, subdivision 11, paragraph (b), or that there were violations that posed an imminent risk of harm to the health and safety of persons in the provider's care.

(b) The administrative law judge shall issue findings of fact, conclusions, and a recommendation within ten business days from the date of hearing. The parties shall have ten calendar days to submit exceptions to the administrative law judge's report. The record shall close at the end of the ten-day period for submission of exceptions. The commissioner's final order shall be issued within ten business days from the close of the record. When an appeal of a temporary immediate suspension or conditional license is withdrawn or dismissed, the commissioner shall issue a final order affirming the temporary immediate suspension or conditional license within ten calendar days of the commissioner's receipt of the withdrawal or dismissal. The license holder is prohibited from operation during the temporary suspension period.

(c) When the final order under paragraph (b) affirms an immediate suspension, and a final licensing sanction is issued under subdivisions 1 and 2 and the licensee appeals that sanction, the licensee is prohibited from operation pending a final commissioner's order after the contested case hearing conducted under chapter 14.

(d) A licensee whose license is temporarily suspended must comply with the requirements for notification and transfer of clients in subdivision 5. These requirements remain if an appeal is requested.

Sec. 14. Minnesota Statutes 2018, section 144A.475, subdivision 5, is amended to read:

Subd. 5. **Plan required.** (a) The process of suspending ~~or~~, revoking, or refusing to renew a license must include a plan for transferring affected ~~clients~~ clients' care to other providers by the home care provider, which will be monitored by the commissioner. Within three ~~business~~ calendar days of being notified of the ~~final~~ revocation, refusal to renew, or suspension ~~action~~, the home care provider shall provide the commissioner, the lead agencies as defined in section 256B.0911, county adult protection and case managers, and the ombudsman for long-term care with the following information:

(1) a list of all clients, including full names and all contact information on file;

(2) a list of each client's representative or emergency contact person, including full names and all contact information on file;

(3) the location or current residence of each client;

(4) the payor sources for each client, including payor source identification numbers; and

(5) for each client, a copy of the client's service plan, and a list of the types of services being provided.

(b) The revocation, refusal to renew, or suspension notification requirement is satisfied by mailing the notice to the address in the license record. The home care provider shall cooperate with the commissioner and the lead agencies, county adult protection and county managers, and the ombudsman for long term care during the process of transferring care of clients to qualified providers. Within three ~~business~~ calendar days of being notified of the final revocation, refusal to renew, or suspension action, the home care provider must notify and disclose to each of the home care provider's clients, or the client's representative or emergency contact persons, that the commissioner is taking action against the home care provider's license by providing a copy of the revocation, refusal to renew, or suspension notice issued by the commissioner. If the provider does not comply with the disclosure requirements in this section, the commissioner, lead agencies, county adult protection and county managers and ombudsman for long-term care shall notify the clients, client representatives, or emergency contact persons, about the action being taken. The revocation, refusal to renew, or suspension notice is public data except for any private data contained therein.

(c) A home care provider subject to this subdivision may continue operating during the period of time home care clients are being transferred to other providers.

Sec. 15. Minnesota Statutes 2018, section 144A.476, subdivision 1, is amended to read:

Subdivision 1. **Prior criminal convictions; owner and managerial officials.** (a) Before the commissioner issues a temporary license, issues a license as a result of an approved change in ownership, or renews a license, an owner or managerial official is required to complete a background study under section 144.057. No person may be involved in the management, operation, or control of a home care provider if the person has been disqualified under chapter 245C. If an individual is disqualified under section 144.057 or chapter 245C, the individual may request reconsideration of the disqualification. If the individual requests reconsideration and the commissioner sets aside or rescinds the disqualification, the individual is eligible to be involved in the management, operation, or control of the provider. If an individual has a disqualification under section 245C.15, subdivision 1, and the disqualification is affirmed, the individual's disqualification is barred from a set aside, and the individual must not be involved in the management, operation, or control of the provider.

(b) For purposes of this section, owners of a home care provider subject to the background check requirement are those individuals whose ownership interest provides sufficient authority or control to affect or change decisions related to the operation of the home care provider. An owner includes a sole proprietor, a general partner, or any other individual whose individual ownership interest can affect the management and direction of the policies of the home care provider.

(c) For the purposes of this section, managerial officials subject to the background check requirement are individuals who provide direct contact as defined in section 245C.02, subdivision 11, or individuals who have the responsibility for the ongoing management or direction of the policies, services, or employees of the home care provider. Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12.

(d) The department shall not issue any license if the applicant or owner or managerial official has been unsuccessful in having a background study disqualification set aside under section 144.057 and chapter 245C; if the owner or managerial official, as an owner or managerial official of another home care provider, was substantially responsible for the other home care provider's failure to substantially comply with sections 144A.43 to 144A.482; or if an owner that has ceased doing business, either individually or as an owner of a home care provider, was issued a correction order for failing to assist clients in violation of this chapter.

(e) Effective July 1, 2021, this section applies to controlling persons as defined in section 144I.01.

Sec. 16. Minnesota Statutes 2018, section 144A.4791, subdivision 10, is amended to read:

Subd. 10. **Termination of service plan.** (a) If a home care provider terminates a service plan with a client, and the client continues to need home care services, the home care provider shall provide the client and the client's representative, if any, with a 30-day written notice of termination which includes the following information:

(1) the effective date of termination;

(2) the reason for termination;

(3) a list of known licensed home care providers in the client's immediate geographic area;

(4) a statement that the home care provider will participate in a coordinated transfer of care of the client to another home care provider, health care provider, or caregiver, as required by the home care bill of rights, section 144A.44, subdivision 1, clause (17);

(5) the name and contact information of a person employed by the home care provider with whom the client may discuss the notice of termination; and

(6) if applicable, a statement that the notice of termination of home care services does not constitute notice of termination of the housing with services contract with a housing with services establishment.

(b) When the home care provider voluntarily discontinues services to all clients, the home care provider must notify the commissioner, lead agencies, and ombudsman for long-term care about its clients and comply with the requirements in this subdivision.

Sec. 17. Minnesota Statutes 2018, section 144A.4799, is amended to read:

144A.4799 DEPARTMENT OF HEALTH LICENSED HOME CARE AND ASSISTED LIVING PROVIDER ADVISORY COUNCIL.

Subdivision 1. **Membership.** The commissioner of health shall appoint eight persons to a home care and assisted living program advisory council consisting of the following:

(1) three public members as defined in section 214.02 who shall be ~~either~~ persons who are currently receiving home care services ~~or~~, persons who have received home care within five years of the application date, persons who have family members receiving home care

services, or persons who have family members who have received home care services within five years of the application date;

(2) three Minnesota home care licensees representing basic and comprehensive levels of licensure who may be a managerial official, an administrator, a supervising registered nurse, or an unlicensed personnel performing home care tasks;

(3) one member representing the Minnesota Board of Nursing; ~~and~~

(4) one member representing the office of ombudsman for long-term care~~.~~;

(5) beginning July 1, 2021, three members representing providers who are eligible to be assisted living licensees pursuant to chapter 144I; and

(6) beginning July 1, 2021, a member of a county health and human services or county adult protection office.

Subd. 2. **Organizations and meetings.** The advisory council shall be organized and administered under section 15.059 with per diems and costs paid within the limits of available appropriations. Meetings will be held quarterly and hosted by the department. Subcommittees may be developed as necessary by the commissioner. Advisory council meetings are subject to the Open Meeting Law under chapter 13D.

Subd. 3. **Duties.** (a) At the commissioner's request, the advisory council shall provide advice regarding regulations of Department of Health licensed home care providers in this chapter, including advice on the following:

(1) community standards for home care practices and assisted living settings;

(2) enforcement of licensing standards and whether certain disciplinary actions are appropriate;

(3) ways of distributing information to licensees and consumers of home care;

(4) training standards;

(5) identifying emerging issues and opportunities in ~~the~~ home care ~~field, including~~ and assisted living;

(6) identifying the use of technology in home and telehealth capabilities;

~~(6)~~ (7) allowable home care licensing modifications and exemptions, including a method for an integrated license with an existing license for rural licensed nursing homes to provide limited home care services in an adjacent independent living apartment building owned by the licensed nursing home; ~~and~~

~~(7)~~ (8) recommendations for studies using the data in section 62U.04, subdivision 4, including but not limited to studies concerning costs related to dementia and chronic disease among an elderly population over 60 and additional long-term care costs, as described in section 62U.10, subdivision 6~~.~~; and

(9) the single unified assisted living resident bill of rights to be used by July 1, 2021, for all new assisted living licensees and by assisted living licensees for the benefit of the assisted living residents.

(b) The advisory council shall perform other duties as directed by the commissioner.

(c) The advisory council shall annually ~~review the balance of the account in the state government special revenue fund described in section 144A.474, subdivision 11, paragraph (i), and~~ make ~~annual~~ recommendations ~~by January 15 directly to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services regarding appropriations~~ to the commissioner for the purposes in section 144A.474, subdivision 11, paragraph (i). The recommendations shall address ways the commissioner may improve protection of the public under existing statutes and laws and include but are not limited to projects that create and administer training of licensees and their employees to improve residents lives, supporting ways that licensees can improve and enhance quality care, ways to provide technical assistance to licensees to improve compliance; information technology and data projects that analyze and communicate information about trends of violations or lead to ways of improving resident care; communications strategies to licensees and the public; and other projects or pilots that benefit residents, families, and the public.

Sec. 18. **REPEALER.**

Minnesota Statutes 2018, section 144A.472, subdivision 4, is repealed.

ARTICLE 19

HUMAN SERVICES FORECAST ADJUSTMENTS

Section 1. **DEPARTMENT OF HUMAN SERVICES FORECAST ADJUSTMENT.**

The dollar amounts shown in the columns marked "Appropriations" are added to or, if shown in parentheses, are subtracted from the appropriations in Laws 2017, First Special Session chapter 6, article 18, from the general fund, or any other fund named, to the commissioner of human services for the purposes specified in this article, to be available for the fiscal year indicated for each purpose. The figure "2019" used in this article means that the appropriations listed are available for the fiscal year ending June 30, 2019.

		APPROPRIATIONS	
		Available for the Year	
		Ending June 30	
		2019	

Sec. 2. **COMMISSIONER OF HUMAN SERVICES**

Subdivision 1. **Total Appropriation**		**$**	**(318,423,000)**
Appropriations by Fund			
	2019		
General	(317,538,000)		
Health Care Access	8,410,000		
Federal TANF	(9,295,000)		
Subd. 2. **Forecasted Programs**			
(a) **Minnesota Family Investment Program (MFIP)/Diversionary Work Program (DWP)**			
Appropriations by Fund			
General	(19,361,000)		
Federal TANF	(8,893,000)		
(b) **MFIP Child Care Assistance**			(16,789,000)
(c) **General Assistance**			(7,928,000)
(d) **Minnesota Supplemental Aid**			(549,000)
(e) **Housing Support**			(13,836,000)
(f) **Northstar Care for Children**			(19,027,000)
(g) **MinnesotaCare**			8,410,000
This appropriation is from the health care access fund.			
(h) **Medical Assistance**			
Appropriations by Fund			
General	(222,176,000)		
Health Care Access	-0-		
(i) **Alternative Care**			-0-

(j) **Consolidated Chemical Dependency Treatment Fund (CCDTF) Entitlement** (17,872,000)

Subd. 3. **Technical Activities** (402,000)

This appropriation is from the federal TANF fund.

Sec. 3. **EFFECTIVE DATE.**

Sections 1 and 2 are effective the day following final enactment.

ARTICLE 20

APPROPRIATIONS

Section 1. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are appropriated to the agencies and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2020" and "2021" used in this article mean that the appropriations listed under them are available for the fiscal year ending June 30, 2020, or June 30, 2021, respectively. "The first year" is fiscal year 2020. "The second year" is fiscal year 2021. "The biennium" is fiscal years 2020 and 2021.

	APPROPRIATIONS	
	Available for the Year	
	Ending June 30	
	2020	**2021**

Sec. 2. **COMMISSIONER OF HUMAN SERVICES**

Subdivision 1. **Total Appropriation**	**$**	**8,258,513,000**	**$** **8,377,920,000**

Appropriations by Fund

	2020	2021
General	7,442,146,000	7,531,758,000
State Government Special Revenue	5,575,000	5,566,000
Health Care Access	527,628,000	551,705,000
Federal TANF	274,650,000	276,245,000

Lottery Prize	1,896,000	1,896,000
Opioid Stewardship	6,618,000	10,750,000

The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **TANF Maintenance of Effort**

(a) **Nonfederal Expenditures.** The commissioner shall ensure that sufficient qualified nonfederal expenditures are made each year to meet the state's maintenance of effort (MOE) requirements of the TANF block grant specified under Code of Federal Regulations, title 45, section 263.1. In order to meet these basic TANF/MOE requirements, the commissioner may report as TANF/MOE expenditures only nonfederal money expended for allowable activities listed in the following clauses:

(1) MFIP cash, diversionary work program, and food assistance benefits under Minnesota Statutes, chapter 256J;

(2) the child care assistance programs under Minnesota Statutes, sections 119B.03 and 119B.05, and county child care administrative costs under Minnesota Statutes, section 119B.15;

(3) state and county MFIP administrative costs under Minnesota Statutes, chapters 256J and 256K;

(4) state, county, and tribal MFIP employment services under Minnesota Statutes, chapters 256J and 256K;

(5) expenditures made on behalf of legal noncitizen MFIP recipients who qualify for

the MinnesotaCare program under Minnesota Statutes, chapter 256L;

(6) qualifying working family credit expenditures under Minnesota Statutes, section 290.0671;

(7) qualifying Minnesota education credit expenditures under Minnesota Statutes, section 290.0674; and

(8) qualifying Head Start expenditures under Minnesota Statutes, section 119A.50.

(b) **Nonfederal Expenditures; Reporting.** For the activities listed in paragraph (a), clauses (2) to (8), the commissioner may report only expenditures that are excluded from the definition of assistance under Code of Federal Regulations, title 45, section 260.31.

(c) **Certain Expenditures Required.** The commissioner shall ensure that the MOE used by the commissioner of management and budget for the February and November forecasts required under Minnesota Statutes, section 16A.103, contains expenditures under paragraph (a), clause (1), equal to at least 16 percent of the total required under Code of Federal Regulations, title 45, section 263.1.

(d) **Limitation; Exceptions.** The commissioner must not claim an amount of TANF/MOE in excess of the 75 percent standard in Code of Federal Regulations, title 45, section 263.1(a)(2), except:

(1) to the extent necessary to meet the 80 percent standard under Code of Federal Regulations, title 45, section 263.1(a)(1), if it

is determined by the commissioner that the state will not meet the TANF work participation target rate for the current year;

(2) to provide any additional amounts under Code of Federal Regulations, title 45, section 264.5, that relate to replacement of TANF funds due to the operation of TANF penalties; and

(3) to provide any additional amounts that may contribute to avoiding or reducing TANF work participation penalties through the operation of the excess MOE provisions of Code of Federal Regulations, title 45, section 261.43 (a)(2).

(e) **Supplemental Expenditures.** For the purposes of paragraph (d), the commissioner may supplement the MOE claim with working family credit expenditures or other qualified expenditures to the extent such expenditures are otherwise available after considering the expenditures allowed in this subdivision.

(f) **Reduction of Appropriations; Exception.** The requirement in Minnesota Statutes, section 256.011, subdivision 3, that federal grants or aids secured or obtained under that subdivision be used to reduce any direct appropriations provided by law, does not apply if the grants or aids are federal TANF funds.

(g) **IT Appropriations Generally.** This appropriation includes funds for information technology projects, services, and support. Notwithstanding Minnesota Statutes, section 16E.0466, funding for information technology project costs shall be incorporated into the

service level agreement and paid to the Office of MN.IT Services by the Department of Human Services under the rates and mechanism specified in that agreement.

(h) **Receipts for Systems Project.** Appropriations and federal receipts for information systems projects for MAXIS, PRISM, MMIS, ISDS, METS, and SSIS must be deposited in the state systems account authorized in Minnesota Statutes, section 256.014. Money appropriated for computer projects approved by the commissioner of the Office of MN.IT Services, funded by the legislature, and approved by the commissioner of management and budget may be transferred from one project to another and from development to operations as the commissioner of human services considers necessary. Any unexpended balance in the appropriation for these projects does not cancel and is available for ongoing development and operations.

(i) **Federal SNAP Education and Training Grants.** Federal funds available during fiscal years 2020 and 2021 for Supplemental Nutrition Assistance Program Education and Training and SNAP Quality Control Performance Bonus grants are appropriated to the commissioner of human services for the purposes allowable under the terms of the federal award. This paragraph is effective the day following final enactment.

Subd. 3. **Working Family Credit as TANF/MOE.**

The commissioner may claim as TANF/MOE up to $6,707,000 per year of working family credit expenditures in each fiscal year.

Subd. 4. **Central Office; Operations**

	Appropriations by Fund	
General	153,377,000	151,082,000
State Government Special Revenue	5,450,000	5,441,000
Health Care Access	20,709,000	22,459,000
Federal TANF	100,000	100,000

(a) **Administrative Recovery; Set-Aside.** The commissioner may invoice local entities through the SWIFT accounting system as an alternative means to recover the actual cost of administering the following provisions:

(1) Minnesota Statutes, section 125A.744, subdivision 3;

(2) Minnesota Statutes, section 245.495, paragraph (b);

(3) Minnesota Statutes, section 256B.0625, subdivision 20, paragraph (k);

(4) Minnesota Statutes, section 256B.0924, subdivision 6, paragraph (g);

(5) Minnesota Statutes, section 256B.0945, subdivision 4, paragraph (d); and

(6) Minnesota Statutes, section 256F.10, subdivision 6, paragraph (b).

(b) **Base Level Adjustment.** The general fund base is $143,583,000 in fiscal year 2022 and $146,013,000 in fiscal year 2023. The health care access fund base is $20,709,000 in fiscal year 2023. The state government special

revenue fund base is $5,442,000 in fiscal year 2023.

Subd. 5. **Central Office; Children and Families**

	Appropriations by Fund	
General	13,353,000	14,204,000
Federal TANF	2,582,000	2,582,000

(a) **Financial Institution Data Match and Payment of Fees.** The commissioner is authorized to allocate up to $310,000 each year in fiscal year 2020 and fiscal year 2021 from the systems special revenue account to make payments to financial institutions in exchange for performing data matches between account information held by financial institutions and the public authority's database of child support obligors as authorized by Minnesota Statutes, section 13B.06, subdivision 7.

(b) **Base Level Adjustment.** The general fund base is $14,440,000 in fiscal year 2022 and $14,693,000 in fiscal year 2023.

Subd. 6. **Central Office; Health Care**

	Appropriations by Fund	
General	22,612,000	23,633,000
Health Care Access	25,358,000	25,056,000

(a) **Nonemergency Medical Transportation Program Audits.** $557,000 in fiscal year 2020 and $1,119,000 in fiscal year 2021 are from the general fund to conduct audits of the nonemergency medical transportation program.

(b) **Base Level Adjustment.** The general fund base is $26,780,000 in fiscal year 2022 and $29,180,000 in fiscal year 2023. The health

care access fund base is $26,340,000 in fiscal year 2022 and $27,088,000 in fiscal year 2023.

Subd. 7. **Central Office; Continuing Care for Older Adults**

	Appropriations by Fund	
General	20,330,000	17,991,000
State Government Special Revenue	125,000	125,000

Base Level Adjustment. The general fund base is $20,486,000 in fiscal year 2022 and $18,006,000 in fiscal year 2023.

Subd. 8. **Central Office; Community Supports**

	Appropriations by Fund	
General	35,081,000	34,979,000
Lottery Prize	163,000	163,000
Opioid Stewardship	218,000	350,000

(a) **Assisted Living Survey.** Beginning in fiscal year 2020, $2,500,000 is appropriated in the even numbered year of each biennium to fund a resident experience survey and family survey for all housing with services sites. This paragraph does not expire.

(b) **Information and Assistance Grant Transfer.** $1,000,000 in fiscal year 2020 and $1,000,000 in fiscal year 2021 are transferred to the Continuing Care for Older Adults administration from the Aging and Adult Services grants for developing the Home and Community Based Report Card for assisted living. This transfer is ongoing.

(c) **Certified Community Behavioral Health Center (CCBHC) Expansion.** $310,000 in fiscal year 2020 and $285,000 in fiscal year 2021 are from the general fund to support CCBHC expansion.

(d) **Base Level Adjustment.** The general fund base is $34,434,000 in fiscal year 2022 and $34,134,000 in fiscal year 2023. The opioid stewardship fund base is $336,000 in fiscal year 2022 and $336,000 in fiscal year 2023.

Subd. 9. **Forecasted Programs; MFIP/DWP**

	Appropriations by Fund	
General	93,888,000	112,508,000
Federal TANF	78,135,000	79,404,000

MFIP Rate Increase. Effective February 1, 2020, the amount of the MFIP cash assistance portion of the transitional standard is increased $100 per month per household. This increase shall be reflected in the MFIP cash assistance portion of the transitional standard published annually by the Department of Human Services. This paragraph does not expire.

Subd. 10. **Forecasted Programs; MFIP Child Care Assistance**	109,270,000	123,202,000

Subd. 11. **Forecasted Programs; General Assistance**	50,563,000	51,200,000

(a) **General Assistance Standard.** The commissioner shall set the monthly standard of assistance for general assistance units consisting of an adult recipient who is childless and unmarried or living apart from parents or a legal guardian at $203. The commissioner may reduce this amount according to Laws 1997, chapter 85, article 3, section 54.

(b) **Emergency General Assistance Limit.** The amount appropriated for emergency general assistance is limited to no more than $6,729,812 in fiscal year 2020 and $6,729,812 in fiscal year 2021. Funds to counties shall be

allocated by the commissioner using the allocation method under Minnesota Statutes, section 256D.06.

Subd. 12. **Forecasted Programs; Minnesota Supplemental Aid** 41,834,000 45,866,000

Subd. 13. **Forecasted Programs; Housing Support** 169,757,000 173,586,000

Subd. 14. **Forecasted Programs; Northstar Care for Children** 86,921,000 94,528,000

Subd. 15. **Forecasted Programs; MinnesotaCare** 26,772,000 29,526,000

(a) **Generally.** This appropriation is from the health care access fund.

(b) **OneCare Buy-In Option.** The fiscal year 2023 base for MinnesotaCare is increased by $112,000,000 to serve as a reserve for the Department of Human Services to operationalize the OneCare Buy-In Option under Minnesota Statutes, chapter 256T. This is a onetime increase.

Subd. 16. **Forecasted Programs; Medical Assistance**

Appropriations by Fund		
General	5,664,289,000	5,682,365,000
Health Care Access	450,574,000	470,449,000

Behavioral Health Services. $1,000,000 in fiscal year 2020 and $1,000,000 in fiscal year 2021 are for behavioral health services provided by hospitals identified under Minnesota Statutes, section 256.969, subdivision 2b, paragraph (a), clause (4). The increase in payments shall be made by increasing the adjustment under Minnesota Statutes, section 256.969, subdivision 2b, paragraph (e), clause (2).

Subd. 17. **Forecasted Programs; Alternative Care** 45,243,000 45,245,000

Alternative Care Transfer. Any money allocated to the alternative care program that is not spent for the purposes indicated does not cancel but must be transferred to the medical assistance account.

Subd. 18. **Forecasted Programs; Chemical Dependency Treatment Fund** 156,941,000 158,166,000

Subd. 19. **Grant Programs; Support Services Grants**

	Appropriations by Fund	
General	8,715,000	8,715,000
Federal TANF	96,213,000	96,311,000

Subd. 20. **Grant Programs; Basic Sliding Fee Child Care Assistance Grants** 63,227,000 74,847,000

(a) **Basic Sliding Fee Waiting List Allocation.** Notwithstanding Minnesota Statutes, section 119B.03, $8,676,000 in fiscal year 2020 and $17,701,000 in fiscal year 2021 are to reduce the basic sliding fee program waiting list as follows:

(1) the calendar year 2020 allocation shall be increased to serve families on the waiting list. To receive funds appropriated for this purpose, a county must have a waiting list in the most recent published waiting list month;

(2) funds shall be distributed proportionately based on the average of the most recent six months of published waiting lists to counties that meet the criteria in clause (1);

(3) allocations in calendar years 2021 and beyond shall be calculated using the allocation formula in Minnesota Statutes, section 119B.03; and

(4) the guaranteed floor for calendar year 2021 shall be based on the revised calendar year 2020 allocation.

(b) **Base Level Adjustment.** The general fund base is $87,802,000 in fiscal year 2022 and $95,282,000 in fiscal year 2023.

Subd. 21. **Grant Programs; Child Care Development Grants** 1,737,000 1,737,000

Subd. 22. **Grant Programs; Child Support Enforcement Grants** 50,000 50,000

Subd. 23. **Grant Programs; Children's Services Grants**

	Appropriations by Fund	
General	40,857,000	45,345,000
Federal TANF	140,000	140,000

(a) **Title IV-E Adoption Assistance.** (1) The commissioner shall allocate funds from the Title IV-E reimbursement to the state from the Fostering Connections to Success and Increasing Adoptions Act for adoptive, foster, and kinship families as required in Minnesota Statutes, section 256N.261.

(2) Additional federal reimbursement to the state as a result of the Fostering Connections to Success and Increasing Adoptions Act's expanded eligibility for title IV-E adoption assistance is for postadoption, foster care, adoption, and kinship services, including a parent-to-parent support network.

(b) **Base Level Adjustment.** The general fund base is $48,283,000 in fiscal year 2022 and $47,998,000 in fiscal year 2023.

Subd. 24. **Grant Programs; Children and Community Service Grants** 59,201,000 59,701,000

(a) **Adult Protection Grants.** $1,000,000 in fiscal year 2020 and $1,500,000 in fiscal year 2021 are for grant funding for adult abuse maltreatment investigations and adult protective services to counties and tribes as allocated and specified under Minnesota Statutes, section 256M.42.

(b) **Base Level Adjustment.** The general fund base is $60,251,000 in fiscal year 2022 and $60,856,000 in fiscal year 2023.

Subd. 25. **Grant Programs; Children and Economic Support Grants** 22,065,000 22,065,000

Minnesota Food Assistance Program. Unexpended funds for the Minnesota food assistance program for fiscal year 2020 do not cancel but are available for this purpose in fiscal year 2021.

Subd. 26. **Grant Programs; Health Care Grants**

Appropriations by Fund		
General	3,711,000	3,711,000
Health Care Access	3,465,000	3,465,000

Subd. 27. **Grant Programs; Other Long-Term Care Grants** 1,925,000 1,925,000

Subd. 28. **Grant Programs; Aging and Adult Services Grants** 31,811,000 31,995,000

Subd. 29. **Grant Programs; Deaf and Hard-of-Hearing Grants** 2,886,000 2,886,000

Subd. 30. **Grant Programs; Disabilities Grants** 22,231,000 22,944,000

(a) **Training of Direct Support Services Providers.** $375,000 in fiscal year 2020 and $375,000 in fiscal year 2021 are for stipends to pay for training of individual providers of direct support services as defined in Minnesota Statutes, section 256B.0711, subdivision 1. This training is available to individual

providers who have completed designated voluntary trainings made available through the State Service Employees International Union Healthcare Minnesota Committee. This is a onetime appropriation. This appropriation is available only if the labor agreement between the state of Minnesota and the Service Employees International Union Healthcare Minnesota under Minnesota Statutes, section 179A.54, is approved under Minnesota Statutes, section 3.855.

(b) **Training for New Worker Orientation.** $125,000 in fiscal year 2020 and $125,000 in fiscal year 2021 are for new worker orientation training and is allocated to the Minnesota State Service Employees International Union Healthcare Minnesota Committee. This is a onetime appropriation. This appropriation is available only if the labor agreement between the state of Minnesota and the Service Employees International Union Healthcare Minnesota under Minnesota Statutes, section 179A.54, is approved under Minnesota Statutes, section 3.855.

(c) **Benefits Planning Grants.** $600,000 in fiscal year 2020 and $600,000 in fiscal year 2021 are to provide grant funding to the Disability Hub for benefits planning to people with disabilities.

(d) **Regional Support for Person-Centered Practices Grants.** $374,000 in fiscal year 2020 and $486,000 in fiscal year 2021 are to extend and expand regional capacity for person-centered planning. This grant funding must be allocated to regional cohorts for

training, coaching, and mentoring for person-centered and collaborative safety practices benefiting people with disabilities, and employees, organizations, and communities serving people with disabilities.

(e) **Disability Hub for Families Grants.** $100,000 in fiscal year 2020 and $200,000 in fiscal year 2021 are for grants to connect families through innovation grants, life planning tools, and website information as they support a child or family member with disabilities.

(f) **Electronic Visit Verification.** $500,000 in fiscal year 2021 is for grants to providers who use a different vendor than the contract with the State of Minnesota for electronic visit verification.

(g) **Base Level Adjustment.** The general fund base is $22,556,000 in fiscal year 2022 and $22,168,000 in fiscal year 2023.

Subd. 31. **Grant Programs; Housing Support Grants**	10,264,000	11,364,000

Subd. 32. **Grant Programs; Adult Mental Health Grants**

Appropriations by Fund		
General	78,708,000	78,377,000
Health Care Access	750,000	750,000
Opioid Stewardship	6,400,000	10,400,000

(a) **Certified Community Behavioral Health Center (CCBHC) Expansion.** $200,000 in fiscal year 2021 is from the general fund for grants for planning, staff training, and other quality improvements that are required to comply with federal CCBHC criteria for three expansion sites.

(b) **Traditional Healing.** $2,400,000 in fiscal year 2020 and $2,400,000 in fiscal year 2021 are from the opioid stewardship fund appropriation to provide grant funding to Tribal Nations and five urban Indian communities for traditional healing practices to American Indians and increase the capacity of culturally specific providers in the behavioral health workforce.

(c) **Opioid Stewardship Fee Distribution to Counties and Tribes.** $4,000,000 in fiscal year 2020 and $4,000,000 in fiscal year 2021 are from the opioid stewardship fund for allocation to county and tribal social service agencies by a formula determined by the commissioner of human services in consultation with counties and tribes.

(d) **Opioid Stewardship Fund Initiatives.** $4,000,000 in fiscal year 2021 is from the opioid stewardship fund for initiatives related to prevention, education, treatment, and services that promote innovation and capacity building to address the opioid addiction and overdose epidemic.

(e) **Base Level Adjustment.** The general fund base is $78,277,000 in fiscal year 2022 and $78,177,000 in fiscal year 2023.

Subd. 33. **Grant Programs; Child Mental Health Grants**	25,726,000	25,726,000

(a) **Children's Intensive Services Reform.** $400,000 in fiscal year 2020 and $400,000 in fiscal year 2021 are appropriated from the general fund for start-up grants to prospective psychiatric residential treatment facility sites for administrative expenses, consulting

services, Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliance, therapeutic resources including evidence-based, culturally appropriate curriculums, and training programs for staff and clients as well as allowable physical renovations to the property.

(b) **Base Level Adjustment.** The general fund base is $26,226,000 in fiscal year 2022 and $26,226,000 in fiscal year 2023.

Subd. 34. **Grant Programs; Chemical Dependency Treatment Support Grants**

	Appropriations by Fund	
General	2,136,000	2,136,000
Lottery Prize	1,733,000	1,733,000

Problem Gambling. $225,000 in fiscal year 2020 and $225,000 in fiscal year 2021 are from the lottery prize fund for a grant to the state affiliate recognized by the National Council on Problem Gambling. The affiliate must provide services to increase public awareness of problem gambling, education, and training for individuals and organizations providing effective treatment services to problem gamblers and their families, and research related to problem gambling.

Subd. 35. **Direct Care and Treatment - Generally**

(a) **Transfer Authority.** Money appropriated to budget activities under this subdivision and subdivisions 36, 37, 38, and 39 may be transferred between budget activities and between years of the biennium with the approval of the commissioner of management and budget.

(b) **State Operated Services Account.** Any balance remaining in the state operated services account at the end of fiscal year 2019 shall be transferred to the general fund.

Subd. 36. **Direct Care and Treatment - Mental Health and Substance Abuse** 129,186,000 130,543,000

(a) **Transfer Authority.** Money previously appropriated to support the continued operations of the Community Addiction Enterprise (C.A.R.E.) program may be transferred to the enterprise fund for C.A.R.E.

(b) **Base Level Adjustment.** The general fund base is $130,539,000 in fiscal year 2022 and $130,539,000 in fiscal year 2023.

Subd. 37. **Direct Care and Treatment - Community-Based Services** 16,630,000 17,177,000

(a) **Transfer Authority.** Money previously appropriated to support the continued operations of the Minnesota State Operated Community Services (MSOCS) program may be transferred to the enterprise fund for MSOCS.

(b) **MSOCS Operating Adjustment.** $1,594,000 in fiscal year 2020 and $3,729,000 in fiscal year 2021 are from the general fund for the Minnesota State Operated Community Services program. The commissioner shall transfer $1,594,000 in fiscal year 2020 and $3,729,000 in fiscal year 2021 to the enterprise fund for MSOCS.

(c) **Base Level Adjustment.** The general fund base is $17,176,000 in fiscal year 2022 and $17,176,000 in fiscal year 2023.

Subd. 38. **Direct Care and Treatment - Forensic Services** 112,126,000 115,342,000

Base Level Adjustment. The general fund base is $115,944,000 in fiscal year 2022 and $115,944,000 in fiscal year 2023.

Subd. 39. **Direct Care and Treatment - Sex Offender Program** 97,243,000 98,689,000

(a) **Transfer Authority.** Money appropriated for the Minnesota sex offender program may be transferred between fiscal years of the biennium with the approval of the commissioner of management and budget.

(b) **Base Level Adjustment.** The general fund base is $99,234,000 in fiscal year 2022 and $99,234,000 in fiscal year 2023.

Subd. 40. **Direct Care and Treatment - Operations** 48,252,000 47,838,000

Base Level Adjustment. The general fund base is $47,837,000 in fiscal year 2022 and $47,837,000 in fiscal year 2023.

Subd. 41. **Technical Activities** 97,381,000 97,708,000

(a) **Generally.** This appropriation is from the federal TANF fund.

(b) **Base Level Adjustment.** The TANF fund base is $97,760,000 in fiscal year 2022 and $97,820,000 in fiscal year 2023.

Sec. 3. **COMMISSIONER OF HEALTH**

Subdivision 1. **Total Appropriation** **$ 253,084,000 $ 260,743,000**

Appropriations by Fund

	2020	2021
General	138,199,000	141,258,000
State Government Special Revenue	59,662,000	61,914,000
Health Care Access	37,510,000	36,607,000

Federal TANF	11,713,000	11,713,000
Opioid Stewardship Fund	6,000,000	9,251,000

The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **Health Improvement**

Appropriations by Fund		
General	98,345,000	97,775,000
State Government Special Revenue	7,232,000	7,162,000
Health Care Access	37,510,000	36,607,000
Federal TANF	11,713,000	11,713,000

(a) **TANF Appropriations.** (1) $3,579,000 of the TANF fund each year is for home visiting and nutritional services listed under Minnesota Statutes, section 145.882, subdivision 7, clauses (6) and (7). Funds must be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1;

(2) $2,000,000 of the TANF fund each year is for decreasing racial and ethnic disparities in infant mortality rates under Minnesota Statutes, section 145.928, subdivision 7;

(3) $4,978,000 of the TANF fund each year is for the family home visiting grant program according to Minnesota Statutes, section 145A.17. $4,000,000 of the funding must be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1. $978,000 of the funding must be distributed to tribal governments according to Minnesota Statutes, section 145A.14, subdivision 2a;

(4) $1,156,000 of the TANF fund each year is for family planning grants under Minnesota Statutes, section 145.925; and

(5) The commissioner may use up to 6.23 percent of the funds appropriated each year to conduct the ongoing evaluations required under Minnesota Statutes, section 145A.17, subdivision 7, and training and technical assistance as required under Minnesota Statutes, section 145A.17, subdivisions 4 and 5.

(b) **TANF Carryforward.** Any unexpended balance of the TANF appropriation in the first year of the biennium does not cancel but is available for the second year.

(c) **Opioid and Other Drug Abuse Prevention.** $6,000,000 in fiscal year 2020 and $9,251,000 in fiscal year 2021 are appropriated from the opioid stewardship fund to the commissioner of health to support a comprehensive, community-based opioid and other drug abuse prevention program. The commissioner may use up to 19 percent in fiscal year 2020 and up to 14 percent in fiscal year 2021 for administration. The remaining funds are allocated as follows:

(1) $1,000,000 each fiscal year is for grants to regional emergency medical services and law enforcement agencies and organizations to purchase opioid antagonists, including Narcan or Naloxone, and to train first responders across Minnesota;

(2) $1,000,000 in fiscal year 2020 and $2,000,000 in fiscal year 2021 are for

community grants authorized in Minnesota Statutes, section 145.9275, subdivision 1;

(3) $2,000,000 in fiscal year 2020 and $4,000,000 in fiscal year 2021 are for tribal government grants in Minnesota Statutes, section 145.9275, subdivision 2; and

(4) $875,000 in fiscal year 2020 and $1,000,000 in fiscal year 2021 are for overdose fatality review grants across Minnesota.

(d) **Comprehensive Suicide Prevention.** $3,929,000 each fiscal year from the general fund appropriations is to support a comprehensive, community-based suicide prevention strategy. The funds are allocated as follows:

(1) $1,291,000 each fiscal year is for community-based suicide prevention grants authorized in Minnesota Statutes, section 145.56, subdivision 2. Specific emphasis must be placed on those communities with the greatest disparities;

(2) $913,000 each fiscal year is to support evidence-based training for educators and school staff and purchase suicide prevention curriculum for student use statewide, as authorized in Minnesota Statutes, section 145.56, subdivision 2;

(3) $205,000 each fiscal year is to implement the Zero Suicide framework with up to 20 behavioral and health care organizations each year to treat individuals at risk for suicide and support those individuals across systems of care upon discharge;

(4) $1,322,000 each fiscal year is to develop and fund a Minnesota-based network of National Suicide Prevention Lifeline, providing statewide coverage;

(5) $198,000 each fiscal year is to conduct suicide fatality reviews to identify the scope of the suicide problem, identify high-risk groups, set priority prevention activities, and monitor the effects of suicide prevention programs; and

(6) the commissioner may retain up to 22.4 percent of the appropriation under this subdivision to administer the comprehensive suicide prevention strategy.

(e) **Statewide Tobacco Cessation.** $1,663,000 in fiscal year 2020 and $2,878,000 in fiscal year 2021 are from the general fund to the commissioner of health for statewide tobacco cessation services under Minnesota Statutes, section 144.397.

(f) **Health Care Access Survey.** $450,000 in fiscal year 2020 is from the health care access fund for the commissioner to continue and improve the Minnesota Health Care Access Survey. This appropriation is added to the department's base budget for even-numbered fiscal years.

(g) **Community Solutions for Healthy Child Development Grant Program.** $2,000,000 in fiscal year 2020 is for the community solutions for healthy child development grant program to promote health and racial equity for young children and their families under Minnesota Statutes, section 145.9285. The

commissioner may use up to 23.5 percent of the total appropriation for administration. This is a onetime appropriation and is available until June 30, 2023.

(h) **Base Level Adjustments.** The health care access fund base is $37,657,000 in fiscal year 2022 and $36,607,000 in fiscal year 2023.

Subd. 3. **Health Protection**

	Appropriations by Fund	
General	28,904,000	32,421,000
State Government Special Revenue	52,430,000	54,752,000

(a) **Vulnerable Adults Program Improvements.** $7,438,000 in fiscal year 2020 and $4,302,000 in fiscal year 2021 are from the general fund for the commissioner to continue necessary current operations improvements to the regulatory activities, systems, analysis, reporting, and communications that contribute to the health, safety, care quality, and abuse prevention for vulnerable adults in Minnesota. $1,103,000 in fiscal year 2020 and $1,103,000 in fiscal year 2021 are from the state government special revenue fund to improve the frequency of home care provider inspections. The state government special revenue appropriations under this paragraph are onetime appropriations.

(b) **Vulnerable Adults Regulatory Reform.** $2,432,000 in fiscal year 2020 and $8,114,000 in fiscal year 2021 are from the general fund for the commissioner to establish the assisted living licensure under Minnesota Statutes, section 144I.01. This is a onetime

appropriation. The commissioner shall transfer fine revenue previously deposited to the state government special revenue fund under Minnesota Statutes, section 144A.474, subdivision 11, which is estimated to be $632,000, to a dedicated account in the state treasury.

(c) **Laboratory Equipment.** $840,000 in fiscal year 2020 and $655,000 in fiscal year 2021 are from the general fund for the commissioner to purchase equipment for the public health laboratory. These appropriations are onetime appropriations and available until June 30, 2023.

(d) **Provider Network Adequacy Reviews.** $231,000 in fiscal year 2020 and $231,000 in fiscal year 2021 are from the general fund for health plan product reviews and licensing of health maintenance organizations. The $77,000 annual transfer from the state government special revenue fund to the general fund required by Laws 2008, chapter 364, section 17, paragraph (b), shall end in fiscal year 2019.

(e) **Base Level Adjustment.** The general fund base is $25,150,000 in fiscal year 2022 and $24,719,000 in fiscal year 2023. The state government special revenue fund base is $67,107,000 in fiscal year 2022 and $67,067,000 in fiscal year 2023.

Subd. 4. **Health Operations**	10,950,000	11,062,000

Sec. 4. **HEALTH-RELATED BOARDS**

Subdivision 1. **Total Appropriation**	**$ 26,498,000**	**$ 25,888,000**

This appropriation is from the state government special revenue fund unless specified otherwise. The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **Board of Chiropractic Examiners**	629,000	641,000
Subd. 3. **Board of Dentistry**	1,503,000	1,450,000
Subd. 4. **Board of Dietetics and Nutrition Practice**	147,000	149,000
Subd. 5. **Board of Marriage and Family Therapy**	384,000	389,000

Base Level Adjustment. The base is $384,000 in fiscal year 2022 and $384,000 in fiscal year 2023.

Subd. 6. **Board of Medical Practice**	6,013,000	5,996,000

(a) **Health Professional Services Program.** This appropriation includes $1,023,000 in fiscal year 2020 and $1,002,000 in fiscal year 2021 for the health professional services program.

(b) **Base Level Adjustment.** The base is $5,912,000 in fiscal year 2022 and $5,868,000 in fiscal year 2023.

Subd. 7. **Board of Nursing**	4,993,000	4,993,000
Subd. 8. **Board of Nursing Home Administrators**	3,733,000	3,201,000

(a) **Administrative Services Unit - Operating Costs.** Of this appropriation, $3,445,000 in fiscal year 2020 and $2,910,000 in fiscal year 2021 are for operating costs of the administrative services unit. The administrative services unit may receive and expend reimbursements for services it performs for other agencies.

(b) **Administrative Services Unit - Volunteer Health Care Provider Program.** Of this appropriation, $150,000 in fiscal year 2020 and $150,000 in fiscal year 2021 are to pay for medical professional liability coverage required under Minnesota Statutes, section 214.40.

(c) **Administrative Services Unit - Retirement Costs.** Of this appropriation, $558,000 in fiscal year 2020 is a onetime appropriation to the administrative services unit to pay for the retirement costs of health-related board employees. This funding may be transferred to the health board incurring retirement costs. Any board that has an unexpended balance for an amount transferred under this paragraph shall transfer the unexpended amount to the administrative services unit. These funds are available either year of the biennium.

(d) **Administrative Services Unit - Contested Cases and Other Legal Proceedings.** Of this appropriation, $200,000 in fiscal year 2020 and $200,000 in fiscal year 2021 are for costs of contested case hearings and other unanticipated costs of legal proceedings involving health-related boards funded under this section. Upon certification by a health-related board to the administrative services unit that costs will be incurred and that there is insufficient money available to pay for the costs out of money currently available to that board, the administrative services unit is authorized to transfer money from this appropriation to the board for

payment of those costs with the approval of the commissioner of management and budget. The commissioner of management and budget must require any board that has an unexpended balance for an amount transferred under this paragraph to transfer the unexpended amount to the administrative services unit to be deposited in the state government special revenue fund.

Subd. 9. **Board of Optometry**	200,000	201,000
Subd. 10. **Board of Pharmacy**	3,599,000	3,629,000

$1,643,000 in fiscal year 2020 and $1,285,000 in fiscal year 2021 are from the opioid stewardship fund.

Subd. 11. **Board of Physical Therapy**	547,000	549,000
Subd. 12. **Board of Podiatric Medicine**	199,000	199,000
Subd. 13. **Board of Psychology**	1,357,000	1,395,000

Base Level Adjustment. The base is $1,355,000 in fiscal year 2022 and $1,355,000 in fiscal year 2023.

Subd. 14. **Board of Social Work**	1,437,000	1,404,000
Subd. 15. **Board of Veterinary Medicine**	345,000	353,000
Subd. 16. **Board of Behavioral Health and Therapy**	937,000	858,000

Base Level Adjustment. The base is $833,000 in fiscal year 2022 and $833,000 in fiscal year 2023.

Subd. 17. **Board of Occupational Therapy Practice**	450,000	456,000

Sec. 5. **EMERGENCY MEDICAL SERVICES REGULATORY BOARD**	**$ 3,747,000**	**$ 3,809,000**

(a) **Cooper/Sams Volunteer Ambulance Program.** $950,000 in fiscal year 2020 and

$950,000 in fiscal year 2021 are for the Cooper/Sams volunteer ambulance program under Minnesota Statutes, section 144E.40.

(1) Of this amount, $861,000 in fiscal year 2020 and $861,000 in fiscal year 2021 are for the ambulance service personnel longevity award and incentive program under Minnesota Statutes, section 144E.40.

(2) Of this amount, $89,000 in fiscal year 2020 and $89,000 in fiscal year 2021 are for the operations of the ambulance service personnel longevity award and incentive program under Minnesota Statutes, section 144E.40.

(b) **EMSRB Operations.** $1,851,000 in fiscal year 2020 and $1,913,000 in fiscal year 2021 are for board operations. The base for this program is $1,880,000 in fiscal year 2022 and $1,880,000 in fiscal year 2023.

(c) **Regional Grants.** $585,000 in fiscal year 2020 and $585,000 in fiscal year 2021 are for regional emergency medical services programs, to be distributed equally to the eight emergency medical service regions under Minnesota Statutes, section 144E.52.

(d) **Ambulance Training Grant.** $585,000 in fiscal year 2020 and $585,000 in fiscal year 2021 are for training grants under Minnesota Statutes, section 144E.35.

(e) **Base Level Adjustment.** The base is $3,776,000 in fiscal year 2022 and $3,776,000 in fiscal year 2023.

Sec. 6. **COUNCIL ON DISABILITY** **$ 1,014,000 $ 1,006,000**

Sec. 7. **OMBUDSMAN FOR MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES** **$ 2,438,000 $ 2,438,000**

Department of Psychiatry Monitoring.

$100,000 in fiscal year 2020 and $100,000 in fiscal year 2021 are for monitoring the Department of Psychiatry at the University of Minnesota.

Sec. 8. **OMBUDSPERSONS FOR FAMILIES** **$ 714,000 $ 723,000**

Sec. 9. Laws 2017, First Special Session chapter 6, article 18, section 2, subdivision 1, is amended to read:

Subdivision 1. **Total Appropriation** **$ 7,548,395,000 $ ~~7,654,331,000~~ 7,654,596,000**

Appropriations by Fund

	2018	~~2019~~ 2019
General	6,819,523,000	~~6,880,153,000~~ 6,880,418,000
State Government Special Revenue	4,274,000	4,274,000
Health Care Access	446,453,000	501,104,000
Federal TANF	276,249,000	266,904,000
Lottery Prize	1,896,000	1,896,000

The amounts that may be spent for each purpose are specified in the following subdivisions.

EFFECTIVE DATE. This section is effective April 1, 2019.

Sec. 10. Laws 2017, First Special Session chapter 6, article 18, section 2, subdivision 3, is amended to read:

Subd. 3. **Central Office; Operations**

Appropriations by Fund

		~~2019~~
General	136,778,000	~~121,009,000~~ 121,024,000
State Government Special Revenue	4,149,000	4,149,000

Health Care Access	21,019,000	21,019,000
Federal TANF	100,000	100,000

(a) **Administrative Recovery; Set-Aside.** The commissioner may invoice local entities through the SWIFT accounting system as an alternative means to recover the actual cost of administering the following provisions:

(1) Minnesota Statutes, section 125A.744, subdivision 3;

(2) Minnesota Statutes, section 245.495, paragraph (b);

(3) Minnesota Statutes, section 256B.0625, subdivision 20, paragraph (k);

(4) Minnesota Statutes, section 256B.0924, subdivision 6, paragraph (g);

(5) Minnesota Statutes, section 256B.0945, subdivision 4, paragraph (d); and

(6) Minnesota Statutes, section 256F.10, subdivision 6, paragraph (b).

(b) **Transfer to Office of Legislative Auditor.** $600,000 in fiscal year 2018 and $600,000 in fiscal year 2019 are for transfer to the Office of the Legislative Auditor for audit activities under Minnesota Statutes, section 3.972, subdivision 2b.

(c) **Base Level Adjustment.** The general fund base is $133,378,000 in fiscal year 2020 and $133,418,000 in fiscal year 2021.

EFFECTIVE DATE. This section is effective April 1, 2019.

Sec. 11. Laws 2017, First Special Session chapter 6, article 18, section 2, subdivision 5, is amended to read:

Subd. 5. **Central Office; Health Care**

Appropriations by Fund		
		~~21,249,000~~
General	20,719,000	21,336,000
Health Care Access	23,697,000	23,804,000

(a) **Integrated Health Partnership Health Information Exchange.** $125,000 in fiscal year 2018 and $250,000 in fiscal year 2019 are from the general fund to contract with state-certified health information exchange vendors to support providers participating in an integrated health partnership under Minnesota Statutes, section 256B.0755, to connect enrollees with community supports and social services and improve collaboration among participating and authorized providers.

(b) **Transfer to Legislative Auditor.** 153,000 in fiscal year 2018 and $153,000 in fiscal year 2019 are from the general fund for transfer to the Office of the Legislative Auditor for the auditor to establish and maintain a team of auditors with the training and experience necessary to fulfill the requirements in Minnesota Statutes, section 3.972, subdivision 2a.

(c) **Base Level Adjustment.** The general fund base is $21,257,000 in fiscal year 2020 and $21,302,000 in fiscal year 2021.

EFFECTIVE DATE. This section is effective April 1, 2019.

Sec. 12. Laws 2017, First Special Session chapter 6, article 18, section 2, subdivision 15, is amended to read:

Subd. 15. **Forecasted Programs; Medical Assistance**

Appropriations by Fund

		~~5,172,292,000~~
General	5,174,139,000	5,172,455,000
Health Care Access	385,159,000	438,848,000

(a) **Behavioral Health Services.** $1,000,000 in fiscal year 2018 and $1,000,000 in fiscal year 2019 are for behavioral health services provided by hospitals identified under Minnesota Statutes, section 256.969, subdivision 2b, paragraph (a), clause (4). The increase in payments shall be made by increasing the adjustment under Minnesota Statutes, section 256.969, subdivision 2b, paragraph (e), clause (2).

(b) **Self-Directed Workforce Collective Bargaining Agreement.** (1) This appropriation includes money to implement a collective bargaining agreement between the state and the Service Employees International Union Healthcare Minnesota (SEIU). This appropriation is not available until the collective bargaining agreement between the state of Minnesota and the Service Employees International Union Healthcare Minnesota under Minnesota Statutes, section 179A.54, is approved as provided in clause (3).

(2) The commissioner of management and budget is authorized to negotiate and enter into a collective bargaining agreement with SEIU under Minnesota Statutes, section 179A.54, subject to clause (1), and subdivision 7, paragraph (f). The economic terms of the collective bargaining agreement may include wage floor increases for direct support workers, paid time off, holiday pay, wage increases for workers serving people with

complex needs, training stipends, and training for direct support workers and for implementation of the registry as outlined in the collective bargaining agreement.

(3) Notwithstanding Minnesota Statutes, sections 3.855, 179A.22, subdivision 4, and 179A.54, subdivision 5, upon approval of a negotiated collective bargaining agreement by the SEIU and the commissioner of management and budget, the commissioner of human services is authorized to implement the negotiated collective bargaining agreement.

EFFECTIVE DATE. This section is effective April 1, 2019.

Sec. 13. **TRANSFER; OPIOID STEWARDSHIP FUND.**

In fiscal year 2020, the commissioner of management and budget shall transfer $13,000,000 from the health care access fund to the opioid stewardship fund. This is a onetime transfer.

Sec. 14. **TRANSFERS; HUMAN SERVICES.**

Subdivision 1. **Grants.** The commissioner of human services, with the approval of the commissioner of management and budget, may transfer unencumbered appropriation balances for the biennium ending June 30, 2021, within fiscal years among the MFIP, general assistance, medical assistance, MinnesotaCare, MFIP child care assistance under Minnesota Statutes, section 119B.05, Minnesota supplemental aid program, group residential housing program, the entitlement portion of Northstar Care for Children under Minnesota Statutes, chapter 256N, and the entitlement portion of the chemical dependency consolidated treatment fund, and between fiscal years of the biennium. The commissioner shall inform the chairs and ranking minority members of the senate Health and Human Services Finance Division and the house of representatives Health and Human Services Finance Committee quarterly about transfers made under this subdivision.

Subd. 2. **Administration.** Positions, salary money, and nonsalary administrative money may be transferred within the Departments of Health and Human Services as the commissioners consider necessary, with the advance approval of the commissioner of

management and budget. The commissioner shall inform the chairs and ranking minority members of the senate Health and Human Services Finance Division and the house of representatives Health and Human Services Finance Committee quarterly about transfers made under this subdivision.

Sec. 15. **INDIRECT COSTS NOT TO FUND PROGRAMS.**

The commissioners of health and human services shall not use indirect cost allocations to pay for the operational costs of any program for which they are responsible.

Sec. 16. **EXPIRATION OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires on June 30, 2021, unless a different expiration date is explicit.

Sec. 17. **EFFECTIVE DATE.**

This article is effective July 1, 2019, unless a different effective date is specified.

119B.16 FAIR HEARING PROCESS.

Subd. 2. **Informal conference.** The county agency shall offer an informal conference to applicants and recipients adversely affected by an agency action to attempt to resolve the dispute. The county agency shall offer an informal conference to providers to whom the county agency has assigned responsibility for an overpayment in an attempt to resolve the dispute. The county agency or the provider may ask the family in whose case the overpayment arose to participate in the informal conference, but the family may refuse to do so. The county agency shall advise adversely affected applicants, recipients, and providers that a request for a conference with the agency is optional and does not delay or replace the right to a fair hearing.

144A.071 MORATORIUM ON CERTIFICATION OF NURSING HOME BEDS.

Subd. 4d. **Consolidation of nursing facilities.** (a) The commissioner of health, in consultation with the commissioner of human services, may approve a request for consolidation of nursing facilities which includes the closure of one or more facilities and the upgrading of the physical plant of the remaining nursing facility or facilities, the costs of which exceed the threshold project limit under subdivision 2, clause (a). The commissioners shall consider the criteria in this section, section 144A.073, and section 256R.40, in approving or rejecting a consolidation proposal. In the event the commissioners approve the request, the commissioner of human services shall calculate an external fixed costs rate adjustment according to clauses (1) to (3):

(1) the closure of beds shall not be eligible for a planned closure rate adjustment under section 256R.40, subdivision 5;

(2) the construction project permitted in this clause shall not be eligible for a threshold project rate adjustment under section 256B.434, subdivision 4f, or a moratorium exception adjustment under section 144A.073; and

(3) the payment rate for external fixed costs for a remaining facility or facilities shall be increased by an amount equal to 65 percent of the projected net cost savings to the state calculated in paragraph (b), divided by the state's medical assistance percentage of medical assistance dollars, and then divided by estimated medical assistance resident days, as determined in paragraph (c), of the remaining nursing facility or facilities in the request in this paragraph. The rate adjustment is effective on the first day of the month of January or July, whichever date occurs first following both the completion of the construction upgrades in the consolidation plan and the complete closure of the facility or facilities designated for closure in the consolidation plan. If more than one facility is receiving upgrades in the consolidation plan, each facility's date of construction completion must be evaluated separately.

(b) For purposes of calculating the net cost savings to the state, the commissioner shall consider clauses (1) to (7):

(1) the annual savings from estimated medical assistance payments from the net number of beds closed taking into consideration only beds that are in active service on the date of the request and that have been in active service for at least three years;

(2) the estimated annual cost of increased case load of individuals receiving services under the elderly waiver;

(3) the estimated annual cost of elderly waiver recipients receiving support under housing support under chapter 256I;

(4) the estimated annual cost of increased case load of individuals receiving services under the alternative care program;

(5) the annual loss of license surcharge payments on closed beds;

(6) the savings from not paying planned closure rate adjustments that the facilities would otherwise be eligible for under section 256R.40; and

(7) the savings from not paying external fixed costs payment rate adjustments from submission of renovation costs that would otherwise be eligible as threshold projects under section 256B.434, subdivision 4f.

(c) For purposes of the calculation in paragraph (a), clause (3), the estimated medical assistance resident days of the remaining facility or facilities shall be computed assuming 95 percent occupancy multiplied by the historical percentage of medical assistance resident days of the remaining facility

or facilities, as reported on the facility's or facilities' most recent nursing facility statistical and cost report filed before the plan of closure is submitted, multiplied by 365.

(d) For purposes of net cost of savings to the state in paragraph (b), the average occupancy percentages will be those reported on the facility's or facilities' most recent nursing facility statistical and cost report filed before the plan of closure is submitted, and the average payment rates shall be calculated based on the approved payment rates in effect at the time the consolidation request is submitted.

(e) To qualify for the external fixed costs payment rate adjustment under this subdivision, the closing facilities shall:

(1) submit an application for closure according to section 256R.40, subdivision 2; and

(2) follow the resident relocation provisions of section 144A.161.

(f) The county or counties in which a facility or facilities are closed under this subdivision shall not be eligible for designation as a hardship area under subdivision 3 for five years from the date of the approval of the proposed consolidation. The applicant shall notify the county of this limitation and the county shall acknowledge this in a letter of support.

144A.472 HOME CARE PROVIDER LICENSE; APPLICATION AND RENEWAL.

Subd. 4. **Multiple units.** Multiple units or branches of a licensee must be separately licensed if the commissioner determines that the units cannot adequately share supervision and administration of services from the main office.

144D.01 DEFINITIONS.

Subd. 2a. **Arranged home care provider.** "Arranged home care provider" means a home care provider licensed under chapter 144A that provides services to some or all of the residents of a housing with services establishment and that is either the establishment itself or another entity with which the establishment has an arrangement.

Subd. 3a. **Direct-care staff.** "Direct-care staff" means staff and employees who provide home care services listed in section 144A.471, subdivisions 6 and 7.

Subd. 6. **Health-related services.** "Health-related services" include professional nursing services, home health aide tasks, or the central storage of medication for residents.

144D.04 HOUSING WITH SERVICES CONTRACTS.

Subd. 2a. **Additional contract requirements.** (a) For a resident receiving one or more health-related services from the establishment's arranged home care provider, as defined in section 144D.01, subdivision 6, the contract must include the requirements in paragraph (b). A restriction of a resident's rights under this subdivision is allowed only if determined necessary for health and safety reasons identified by the home care provider's registered nurse in an initial assessment or reassessment, as defined under section 144A.4791, subdivision 8, and documented in the written service plan under section 144A.4791, subdivision 9. Any restrictions of those rights for people served under sections 256B.0915 and 256B.49 must be documented in the resident's coordinated service and support plan (CSSP), as defined under sections 256B.0915, subdivision 6 and 256B.49, subdivision 15.

(b) The contract must include a statement:

(1) regarding the ability of a resident to furnish and decorate the resident's unit within the terms of the lease;

(2) regarding the resident's right to access food at any time;

(3) regarding a resident's right to choose the resident's visitors and times of visits;

(4) regarding the resident's right to choose a roommate if sharing a unit; and

(5) notifying the resident of the resident's right to have and use a lockable door to the resident's unit. The landlord shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible.

144D.045 INFORMATION CONCERNING ARRANGED HOME CARE PROVIDERS.

If a housing with services establishment has one or more arranged home care providers, the establishment shall arrange to have that arranged home care provider deliver the following information in writing to a prospective resident, prior to the date on which the prospective resident executes a contract with the establishment or the prospective resident's move-in date, whichever is earlier:

(1) the name, mailing address, and telephone number of the arranged home care provider;

(2) the name and mailing address of at least one natural person who is authorized to accept service of process on behalf of the entity described in clause (1);

(3) a description of the process through which a home care service agreement or service plan between a resident and the arranged home care provider, if any, may be modified, amended, or terminated;

(4) the arranged home care provider's billing and payment procedures and requirements; and

(5) any limits to the services available from the arranged provider.

144D.06 OTHER LAWS.

In addition to registration under this chapter, a housing with services establishment must comply with chapter 504B and the provisions of section 325F.72, and shall obtain and maintain all other licenses, permits, registrations, or other governmental approvals required of it. A housing with services establishment is not required to obtain a lodging license under chapter 157 and related rules.

144D.09 TERMINATION OF LEASE.

The housing with services establishment shall include with notice of termination of lease information about how to contact the ombudsman for long-term care, including the address and telephone number along with a statement of how to request problem-solving assistance.

144D.10 MANAGER REQUIREMENTS.

(a) The person primarily responsible for oversight and management of a housing with services establishment, as designated by the owner of the housing with services establishment, must obtain at least 30 hours of continuing education every two years of employment as the manager in topics relevant to the operations of the housing with services establishment and the needs of its tenants. Continuing education earned to maintain a professional license, such as nursing home administrator license, nursing license, social worker license, and real estate license, can be used to complete this requirement.

(b) For managers of establishments identified in section 325F.72, this continuing education must include at least eight hours of documented training on the topics identified in section 144D.065, paragraph (b), within 160 working hours of hire, and two hours of training on these topics for each 12 months of employment thereafter.

(c) For managers of establishments not covered by section 325F.72, but who provide assisted living services under chapter 144G, this continuing education must include at least four hours of documented training on the topics identified in section 144D.065, paragraph (b), within 160 working hours of hire, and two hours of training on these topics for each 12 months of employment thereafter.

(d) A statement verifying compliance with the continuing education requirement must be included in the housing with services establishment's annual registration to the commissioner of health. The establishment must maintain records for at least three years demonstrating that the person primarily responsible for oversight and management of the establishment has attended educational programs as required by this section.

(e) New managers may satisfy the initial dementia training requirements by producing written proof of previously completed required training within the past 18 months.

(f) This section does not apply to an establishment registered under section 144D.025 serving the homeless.

144G.01 DEFINITIONS.

Subdivision 1. **Scope; other definitions.** For purposes of sections 144G.01 to 144G.05, the following definitions apply. In addition, the definitions provided in section 144D.01 also apply to sections 144G.01 to 144G.05.

Subd. 2. **Assisted living.** "Assisted living" means a service or package of services advertised, marketed, or otherwise described, offered, or promoted using the phrase "assisted living" either alone or in combination with other words, whether orally or in writing, and which is subject to the requirements of this chapter.

Subd. 3. **Assisted living client; client.** "Assisted living client" or "client" means a housing with services resident who receives assisted living that is subject to the requirements of this chapter.

Subd. 4. **Commissioner.** "Commissioner" means the commissioner of health.

144G.02 ASSISTED LIVING; PROTECTED TITLE; REGULATORY FUNCTION.

Subdivision 1. **Protected title; restriction on use.** No person or entity may use the phrase "assisted living," whether alone or in combination with other words and whether orally or in writing, to advertise, market, or otherwise describe, offer, or promote itself, or any housing, service, service package, or program that it provides within this state, unless the person or entity is a housing with services establishment that meets the requirements of this chapter, or is a person or entity that provides some or all components of assisted living that meet the requirements of this chapter. A person or entity entitled to use the phrase "assisted living" shall use the phrase only in the context of its participation in assisted living that meets the requirements of this chapter. A housing with services establishment offering or providing assisted living that is not made available to residents in all of its housing units shall identify the number or location of the units in which assisted living is available, and may not use the term "assisted living" in the name of the establishment registered with the commissioner under chapter 144D, or in the name the establishment uses to identify itself to residents or the public.

Subd. 2. **Authority of commissioner.** (a) The commissioner, upon receipt of information that may indicate the failure of a housing with services establishment, the arranged home care provider, an assisted living client, or an assisted living client's representative to comply with a legal requirement to which one or more of the entities may be subject, shall make appropriate referrals to other governmental agencies and entities having jurisdiction over the subject matter. The commissioner may also make referrals to any public or private agency the commissioner considers available for appropriate assistance to those involved.

(b) In addition to the authority with respect to licensed home care providers under section 144A.45 and with respect to housing with services establishments under chapter 144D, the commissioner shall have standing to bring an action for injunctive relief in the district court in the district in which a housing with services establishment is located to compel the housing with services establishment or the arranged home care provider to meet the requirements of this chapter or other requirements of the state or of any county or local governmental unit to which the establishment or arranged home care provider is otherwise subject. Proceedings for securing an injunction may be brought by the commissioner through the attorney general or through the appropriate county attorney. The sanctions in this section do not restrict the availability of other sanctions.

144G.03 ASSISTED LIVING REQUIREMENTS.

Subdivision 1. **Verification in annual registration.** A registered housing with services establishment using the phrase "assisted living," pursuant to section 144G.02, subdivision 1, shall verify to the commissioner in its annual registration pursuant to chapter 144D that the establishment is complying with sections 144G.01 to 144G.05, as applicable.

Subd. 2. **Minimum requirements for assisted living.** (a) Assisted living shall be provided or made available only to individuals residing in a registered housing with services establishment. Except as expressly stated in this chapter, a person or entity offering assisted living may define the available services and may offer assisted living to all or some of the residents of a housing with services establishment. The services that comprise assisted living may be provided or made available directly by a housing with services establishment or by persons or entities with which the housing with services establishment has made arrangements.

(b) A person or entity entitled to use the phrase "assisted living," according to section 144G.02, subdivision 1, shall do so only with respect to a housing with services establishment, or a service,

service package, or program available within a housing with services establishment that, at a minimum:

(1) provides or makes available health-related services under a home care license. At a minimum, health-related services must include:

(i) assistance with self-administration of medication, medication management, or medication administration as defined in section 144A.43; and

(ii) assistance with at least three of the following seven activities of daily living: bathing, dressing, grooming, eating, transferring, continence care, and toileting.

All health-related services shall be provided in a manner that complies with applicable home care licensure requirements in chapter 144A and sections 148.171 to 148.285;

(2) provides necessary assessments of the physical and cognitive needs of assisted living clients by a registered nurse, as required by applicable home care licensure requirements in chapter 144A and sections 148.171 to 148.285;

(3) has and maintains a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by applicable home care licensure requirements in chapter 144A and sections 148.171 to 148.285;

(4) provides staff access to an on-call registered nurse 24 hours per day, seven days per week;

(5) has and maintains a system to check on each assisted living client at least daily;

(6) provides a means for assisted living clients to request assistance for health and safety needs 24 hours per day, seven days per week, from the establishment or a person or entity with which the establishment has made arrangements;

(7) has a person or persons available 24 hours per day, seven days per week, who is responsible for responding to the requests of assisted living clients for assistance with health or safety needs, who shall be:

(i) awake;

(ii) located in the same building, in an attached building, or on a contiguous campus with the housing with services establishment in order to respond within a reasonable amount of time;

(iii) capable of communicating with assisted living clients;

(iv) capable of recognizing the need for assistance;

(v) capable of providing either the assistance required or summoning the appropriate assistance; and

(vi) capable of following directions;

(8) offers to provide or make available at least the following supportive services to assisted living clients:

(i) two meals per day;

(ii) weekly housekeeping;

(iii) weekly laundry service;

(iv) upon the request of the client, reasonable assistance with arranging for transportation to medical and social services appointments, and the name of or other identifying information about the person or persons responsible for providing this assistance;

(v) upon the request of the client, reasonable assistance with accessing community resources and social services available in the community, and the name of or other identifying information about the person or persons responsible for providing this assistance; and

(vi) periodic opportunities for socialization; and

(9) makes available to all prospective and current assisted living clients information consistent with the uniform format and the required components adopted by the commissioner under section 144G.06. This information must be made available beginning no later than six months after the commissioner makes the uniform format and required components available to providers according to section 144G.06.

Subd. 3. **Exemption from awake-staff requirement.** A housing with services establishment that offers or provides assisted living is exempt from the requirement in subdivision 2, paragraph (b), clause (7), item (i), that the person or persons available and responsible for responding to requests for assistance must be awake, if the establishment meets the following requirements:

(1) the establishment has a maximum capacity to serve 12 or fewer assisted living clients;

(2) the person or persons available and responsible for responding to requests for assistance are physically present within the housing with services establishment in which the assisted living clients reside;

(3) the establishment has a system in place that is compatible with the health, safety, and welfare of the establishment's assisted living clients;

(4) the establishment's housing with services contract, as required by section 144D.04, includes a statement disclosing the establishment's qualification for, and intention to rely upon, this exemption;

(5) the establishment files with the commissioner, for purposes of public information but not review or approval by the commissioner, a statement describing how the establishment meets the conditions in clauses (1) to (4), and makes a copy of this statement available to actual and prospective assisted living clients; and

(6) the establishment indicates on its housing with services registration, under section 144D.02 or 144D.03, as applicable, that it qualifies for and intends to rely upon the exemption under this subdivision.

Subd. 4. **Nursing assessment.** (a) A housing with services establishment offering or providing assisted living shall:

(1) offer to have the arranged home care provider conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a service plan prior to the date on which a prospective resident executes a contract with a housing with services establishment or the date on which a prospective resident moves in, whichever is earlier; and

(2) inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a housing with services establishment or the date on which a prospective resident moves in, whichever is earlier.

(b) An arranged home care provider is not obligated to conduct a nursing assessment by a registered nurse when requested by a prospective resident if either the geographic distance between the prospective resident and the provider, or urgent or unexpected circumstances, do not permit the assessment to be conducted prior to the date on which the prospective resident executes a contract or moves in, whichever is earlier. When such circumstances occur, the arranged home care provider shall offer to conduct a telephone conference whenever reasonably possible.

(c) The arranged home care provider shall comply with applicable home care licensure requirements in chapter 144A and sections 148.171 to 148.285, with respect to the provision of a nursing assessment prior to the delivery of nursing services and the execution of a home care service plan or service agreement.

Subd. 5. **Assistance with arranged home care provider.** The housing with services establishment shall provide each assisted living client with identifying information about a person or persons reasonably available to assist the client with concerns the client may have with respect to the services provided by the arranged home care provider. The establishment shall keep each assisted living client reasonably informed of any changes in the personnel referenced in this subdivision. Upon request of the assisted living client, such personnel or designee shall provide reasonable assistance to the assisted living client in addressing concerns regarding services provided by the arranged home care provider.

Subd. 6. **Termination of housing with services contract.** If a housing with services establishment terminates a housing with services contract with an assisted living client, the establishment shall provide the assisted living client, and the legal or designated representative of the assisted living client, if any, with a written notice of termination which includes the following information:

(1) the effective date of termination;

(2) the section of the contract that authorizes the termination;

(3) without extending the termination notice period, an affirmative offer to meet with the assisted living client and, if applicable, client representatives, within no more than five business days of the date of the termination notice to discuss the termination;

(4) an explanation that:

(i) the assisted living client must vacate the apartment, along with all personal possessions, on or before the effective date of termination;

(ii) failure to vacate the apartment by the date of termination may result in the filing of an eviction action in court by the establishment, and that the assisted living client may present a defense, if any, to the court at that time; and

(iii) the assisted living client may seek legal counsel in connection with the notice of termination;

(5) a statement that, with respect to the notice of termination, reasonable accommodation is available for the disability of the assisted living client, if any; and

(6) the name and contact information of the representative of the establishment with whom the assisted living client or client representatives may discuss the notice of termination.

144G.04 RESERVATION OF RIGHTS.

Subdivision 1. **Use of services.** Nothing in this chapter requires an assisted living client to utilize any service provided or made available in assisted living.

Subd. 2. **Housing with services contracts.** Nothing in this chapter requires a housing with services establishment to execute or refrain from terminating a housing with services contract with a prospective or current resident who is unable or unwilling to meet the requirements of residency, with or without assistance.

Subd. 3. **Provision of services.** Nothing in this chapter requires the arranged home care provider to offer or continue to provide services under a service agreement or service plan to a prospective or current resident of the establishment whose needs cannot be met by the arranged home care provider.

Subd. 4. **Altering operations; service packages.** Nothing in this chapter requires a housing with services establishment or arranged home care provider offering assisted living to fundamentally alter the nature of the operations of the establishment or the provider in order to accommodate the request or need for facilities or services by any assisted living client, or to refrain from requiring, as a condition of residency, that an assisted living client pay for a package of assisted living services even if the client does not choose to utilize all or some of the services in the package.

144G.05 REIMBURSEMENT UNDER ASSISTED LIVING SERVICE PACKAGES.

Notwithstanding the provisions of this chapter, the requirements for the elderly waiver program's assisted living payment rates under section 256B.0915, subdivision 3e, shall continue to be effective and providers who do not meet the requirements of this chapter may continue to receive payment under section 256B.0915, subdivision 3e, as long as they continue to meet the definitions and standards for assisted living and assisted living plus set forth in the federally approved Elderly Home and Community Based Services Waiver Program (Control Number 0025.91). Providers of assisted living for the community access for disability inclusion (CADI) and Brain Injury (BI) waivers shall continue to receive payment as long as they continue to meet the definitions and standards for assisted living and assisted living plus set forth in the federally approved CADI and BI waiver plans.

144G.06 UNIFORM CONSUMER INFORMATION GUIDE.

The commissioner shall adopt a uniform format for the guide to be used by individual providers, and the required components of materials to be used by providers to inform assisted living clients of their legal rights, and shall make the uniform format and the required components available to assisted living providers.

214.17 HIV, HBV, AND HCV PREVENTION PROGRAM; PURPOSE AND SCOPE.

Sections 214.17 to 214.25 are intended to promote the health and safety of patients and regulated persons by reducing the risk of infection in the provision of health care.

214.18 DEFINITIONS.

Subdivision 1. **Board.** "Board" means the Boards of Dentistry, Medical Practice, Nursing, and Podiatric Medicine. For purposes of sections 214.19, subdivisions 4 and 5; 214.20, paragraph (1); and 214.24, board also includes the Board of Chiropractic Examiners.

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of health.

Subd. 3. **HBV.** "HBV" means the hepatitis B virus with the e antigen present in the most recent blood test.

Subd. 3a. **HCV.** "HCV" means the hepatitis C virus.

Subd. 4. **HIV.** "HIV" means the human immunodeficiency virus.

Subd. 5. **Regulated person.** "Regulated person" means a licensed dental hygienist, dentist, physician, nurse who is currently registered as a registered nurse or licensed practical nurse, podiatrist, a registered dental assistant, a physician assistant, and for purposes of sections 214.19, subdivisions 4 and 5; 214.20, paragraph (a); and 214.24, a chiropractor.

214.19 REPORTING OBLIGATIONS.

Subdivision 1. **Permission to report.** A person with actual knowledge that a regulated person has been diagnosed as infected with HIV, HBV, or HCV may file a report with the commissioner.

Subd. 2. **Self-reporting.** A regulated person who is diagnosed as infected with HIV, HBV, or HCV shall report that information to the commissioner promptly, and as soon as medically necessary for disease control purposes but no more than 30 days after learning of the diagnosis or 30 days after becoming licensed or registered by the state.

Subd. 3. **Mandatory reporting.** A person or institution required to report HIV, HBV, or HCV status to the commissioner under Minnesota Rules, parts 4605.7030, subparts 1 to 4 and 6, and 4605.7040, shall, at the same time, notify the commissioner if the person or institution knows that the reported person is a regulated person.

Subd. 4. **Infection control reporting.** A regulated person shall, within ten days, report to the appropriate board personal knowledge of a serious failure or a pattern of failure by another regulated person to comply with accepted and prevailing infection control procedures related to the prevention of HIV, HBV, and HCV transmission. In lieu of reporting to the board, the regulated person may make the report to a designated official of the hospital, nursing home, clinic, or other institution or agency where the failure to comply with accepted and prevailing infection control procedures occurred. The designated official shall report to the appropriate board within 30 days of receiving a report under this subdivision. The report shall include specific information about the response by the institution or agency to the report. A regulated person shall not be discharged or discriminated against for filing a complaint in good faith under this subdivision.

Subd. 5. **Immunity.** A person is immune from civil liability or criminal prosecution for submitting a report in good faith to the commissioner or to a board under this section.

214.20 GROUNDS FOR DISCIPLINARY OR RESTRICTIVE ACTION.

A board may refuse to grant a license or registration or may impose disciplinary or restrictive action against a regulated person who:

(1) fails to follow accepted and prevailing infection control procedures, including a failure to conform to current recommendations of the Centers for Disease Control for preventing the transmission of HIV, HBV, and HCV, or fails to comply with infection control rules promulgated by the board. Injury to a patient need not be established;

(2) fails to comply with any requirement of sections 214.17 to 214.24; or

(3) fails to comply with any monitoring or reporting requirement.

214.21 TEMPORARY SUSPENSION.

The board may, without hearing, temporarily suspend the right to practice of a regulated person if the board finds that the regulated person has refused to submit to or comply with monitoring under section 214.23. The suspension shall take effect upon written notice to the regulated person specifying the statute or rule violated. The suspension shall remain in effect until the board issues a final order based on a stipulation or after a hearing. At the time the board issues the suspension notice, the board shall schedule a disciplinary hearing to be held under chapter 14. The regulated

person shall be provided with at least 20 days' notice of a hearing held under this section. The hearing shall be scheduled to begin no later than 30 days after the issuance of the suspension order.

214.22 NOTICE; ACTION.

If the board has reasonable grounds to believe a regulated person infected with HIV, HBV, or HCV has done or omitted doing any act that would be grounds for disciplinary action under section 214.20, the board may take action after giving notice three business days before the action, or a lesser time if deemed necessary by the board. The board may:

(1) temporarily suspend the regulated person's right to practice under section 214.21;

(2) require the regulated person to appear personally at a conference with representatives of the board and to provide information relating to the regulated person's health or professional practice; and

(3) take any other lesser action deemed necessary by the board for the protection of the public.

214.23 MONITORING.

Subdivision 1. **Commissioner of health.** The board shall enter into a contract with the commissioner to perform the functions in subdivisions 2 and 3. The contract shall provide that:

(1) unless requested to do otherwise by a regulated person, a board shall refer all regulated persons infected with HIV, HBV, or HCV to the commissioner;

(2) the commissioner may choose to refer any regulated person who is infected with HIV, HBV, or HCV as well as all information related thereto to the person's board at any time for any reason, including but not limited to: the degree of cooperation and compliance by the regulated person; the inability to secure information or the medical records of the regulated person; or when the facts may present other possible violations of the regulated persons practices act. Upon request of the regulated person who is infected with HIV, HBV, or HCV the commissioner shall refer the regulated person and all information related thereto to the person's board. Once the commissioner has referred a regulated person to a board, the board may not thereafter submit it to the commissioner to establish a monitoring plan unless the commissioner of health consents in writing;

(3) a board shall not take action on grounds relating solely to the HIV, HBV, or HCV status of a regulated person until after referral by the commissioner; and

(4) notwithstanding sections 13.39 and 13.41 and chapters 147, 147A, 148, 150A, 153, and 214, a board shall forward to the commissioner any information on a regulated person who is infected with HIV, HBV, or HCV that the Department of Health requests.

Subd. 2. **Monitoring plan.** After receiving a report that a regulated person is infected with HIV, HBV, or HCV, the board or the commissioner acting on behalf of the board shall evaluate the past and current professional practice of the regulated person to determine whether there has been a violation under section 214.20. After evaluation of the regulated person's past and current professional practice, the board or the commissioner, acting on behalf of the board, shall establish a monitoring plan for the regulated person. The monitoring plan may:

(1) address the scope of a regulated person's professional practice when the board or the commissioner, acting on behalf of the board, determines that the practice constitutes an identifiable risk of transmission of HIV, HBV, or HCV from the regulated person to the patient;

(2) include the submission of regular reports at a frequency determined by the board or the commissioner, acting on behalf of the board, regarding the regulated person's health status; and

(3) include any other provisions deemed reasonable by the board or the commissioner of health, acting on behalf of the board.

The board or commissioner, acting on behalf of the board, may enter into agreements with qualified persons to perform monitoring on its behalf. The regulated person shall comply with any monitoring plan established under this subdivision.

Subd. 3. **Expert review panel.** The board or the commissioner acting on behalf of the board may appoint an expert review panel to assist in the performance of the responsibilities under this section. In consultations with the expert review panel, the commissioner or board shall, to the extent possible, protect the identity of the regulated person. When an expert review panel is appointed, it must contain at least one member appointed by the commissioner and one professional member appointed by the board. The panel shall provide expert assistance to the board, or to the commissioner

acting on behalf of the board, in the subjects of infectious diseases, epidemiology, practice techniques used by regulated persons, and other subjects determined by the board or by the commissioner acting on behalf of the board. Members of the expert review panel are subject to those provisions of chapter 13 that restrict the commissioner or the board under Laws 1992, chapter 559, article 1.

Subd. 4. **Immunity.** Members of the board or the commissioner acting on behalf of the board, and persons who participate on an expert review panel or who assist the board or the commissioner in monitoring the practice of a regulated person, are immune from civil liability or criminal prosecution for any actions, transactions, or publications made in good faith and in execution of, or relating to, their duties under sections 214.17 to 214.24, except that no immunity shall be available for persons who have knowingly violated any provision of chapter 13.

214.24 INSPECTION OF PRACTICE.

Subdivision 1. **Authority.** The board is authorized to conduct inspections of the clinical practice of a regulated person to determine whether the regulated person is following accepted and prevailing infection control procedures. The board shall provide at least three business days' notice to the clinical practice prior to the inspection. The clinical practice of a regulated person includes any location where the regulated person practices that is not an institution licensed and subject to inspection by the commissioner of health. During the course of inspections the privacy and confidentiality of patients and regulated persons shall be maintained. The board may require on license renewal forms that regulated persons inform the board of all locations where they practice.

Subd. 2. **Access; records.** An inspector from the board shall have access, during reasonable business hours for purposes of inspection, to all areas of the practice setting where patient care is rendered or drugs or instruments are held that come into contact with a patient. An inspector is authorized to interview employees and regulated persons in the performance of an inspection, to observe infection control procedures, test equipment used to sterilize instruments, and to review and copy all relevant records, excluding patient health records. In performing these responsibilities, inspectors shall make reasonable efforts to respect and preserve patient privacy and the privacy of the regulated person. Boards are authorized to conduct joint inspections and to share information obtained under this section. The boards shall contract with the commissioner to perform the duties under this subdivision.

Subd. 3. **Board action.** If accepted and prevailing infection control techniques are not being followed, the board may educate the regulated person or take other actions. The board and the inspector shall maintain patient confidentiality in any action resulting from the inspection.

Subd. 4. **Rulemaking.** A board is authorized to adopt rules setting standards for infection control procedures. Boards shall engage in joint rulemaking. Boards must seek and consider the advice of the commissioner of health before adopting rules. No inspections shall be conducted under this section until after infection control rules have been adopted. Each board is authorized to provide educational information and training to regulated persons regarding infection control. All regulated persons who are employers shall make infection control rules available to employees who engage in functions related to infection control.

245.462 DEFINITIONS.

Subd. 4a. **Clinical supervision.** "Clinical supervision" means the oversight responsibility for individual treatment plans and individual mental health service delivery, including that provided by the case manager. Clinical supervision must be accomplished by full or part-time employment of or contracts with mental health professionals. Clinical supervision must be documented by the mental health professional cosigning individual treatment plans and by entries in the client's record regarding supervisory activities.

245E.06 ADMINISTRATIVE SANCTIONS.

Subd. 2. **Written notice of department sanction; sanction effective date; informal meeting.** (a) The department shall give notice in writing to a person of an administrative sanction that is to be imposed. The notice shall be sent by mail as defined in section 245E.01, subdivision 11.

(b) The notice shall state:

(1) the factual basis for the department's determination;

(2) the sanction the department intends to take;

(3) the dollar amount of the monetary recovery or recoupment, if any;

(4) how the dollar amount was computed;

(5) the right to dispute the department's determination and to provide evidence;

(6) the right to appeal the department's proposed sanction; and

(7) the option to meet informally with department staff, and to bring additional documentation or information, to resolve the issues.

(c) In cases of determinations resulting in denial or termination of payments, in addition to the requirements of paragraph (b), the notice must state:

(1) the length of the denial or termination;

(2) the requirements and procedures for reinstatement; and

(3) the provider's right to submit documents and written arguments against the denial or termination of payments for review by the department before the effective date of denial or termination.

(d) The submission of documents and written argument for review by the department under paragraph (b), clause (5) or (7), or paragraph (c), clause (3), does not stay the deadline for filing an appeal.

(e) Notwithstanding section 245E.03, subdivision 4, the effective date of the proposed sanction shall be 30 days after the license holder's, provider's, controlling individual's, or recipient's receipt of the notice, unless timely appealed. If a timely appeal is made, the proposed sanction shall be delayed pending the final outcome of the appeal. Implementation of a proposed sanction following the resolution of a timely appeal may be postponed if, in the opinion of the department, the delay of sanction is necessary to protect the health or safety of children in care. The department may consider the economic hardship of a person in implementing the proposed sanction, but economic hardship shall not be a determinative factor in implementing the proposed sanction.

(f) Requests for an informal meeting to attempt to resolve issues and requests for appeals must be sent or delivered to the department's Office of Inspector General, Financial Fraud and Abuse Division.

Subd. 4. **Consolidated hearings with licensing sanction.** If a financial misconduct sanction has an appeal hearing right and it is timely appealed, and a licensing sanction exists for which there is an appeal hearing right and the sanction is timely appealed, and the overpayment recovery action and licensing sanction involve the same set of facts, the overpayment recovery action and licensing sanction must be consolidated in the contested case hearing related to the licensing sanction.

Subd. 5. **Effect of department's administrative determination or sanction.** Unless a timely and proper appeal is received by the department, the department's administrative determination or sanction shall be considered a final department determination.

246.18 DISPOSAL OF FUNDS.

Subd. 8. **State-operated services account.** (a) The state-operated services account is established in the special revenue fund. Revenue generated by new state-operated services listed under this section established after July 1, 2010, that are not enterprise activities must be deposited into the state-operated services account, unless otherwise specified in law:

(1) intensive residential treatment services;

(2) foster care services; and

(3) psychiatric extensive recovery treatment services.

(b) Funds deposited in the state-operated services account are appropriated to the commissioner of human services for the purposes of:

(1) providing services needed to transition individuals from institutional settings within state-operated services to the community when those services have no other adequate funding source; and

(2) funding the operation of the intensive residential treatment service program in Willmar.

Subd. 9. **Transfers.** The commissioner may transfer state mental health grant funds to the account in subdivision 8 for noncovered allowable costs of a provider certified and licensed under section 256B.0622 and operating under section 246.014.

252.41 DEFINITIONS.

Subd. 8. **Supported employment.** "Supported employment" means employment of a person with a disability so severe that the person needs ongoing training and support to get and keep a job in which:

(1) the person engages in paid work at a work site where individuals without disabilities who do not require public subsidies also may be employed;

(2) public funds are necessary to provide ongoing training and support services throughout the period of the person's employment; and

(3) the person has the opportunity for social interaction with individuals who do not have disabilities and who are not paid caregivers.

252.431 SUPPORTED EMPLOYMENT SERVICES; DEPARTMENTAL DUTIES; COORDINATION.

The commissioners of employment and economic development, human services, and education shall ensure that supported employment services provided as part of a comprehensive service system will:

(1) provide the necessary supports to assist persons with severe disabilities to obtain and maintain employment in normalized work settings available to the general work force that:

(i) maximize community and social integration; and

(ii) provide job opportunities that meet the individual's career potential and interests;

(2) allow persons with severe disabilities to actively participate in the planning and delivery of community-based employment services at the individual, local, and state level; and

(3) be coordinated among the Departments of Human Services, Employment and Economic Development, and Education to:

(i) promote the most efficient and effective funding;

(ii) avoid duplication of services; and

(iii) improve access and transition to employability services.

The commissioners of employment and economic development, human services, and education shall report to the legislature by January 1993 on the steps taken to implement this section.

252.451 BUSINESS AGREEMENTS; SUPPORT AND SUPERVISION OF PERSONS WITH DISABILITIES.

Subdivision 1. **Definition.** For the purposes of this section, "qualified business" means a business that employs primarily nondisabled persons and will employ persons with developmental disabilities. For purposes of this section, licensed providers of residential services for persons with developmental disabilities are not a qualified business. A qualified business and its employees are exempt from Minnesota Rules, parts 9525.1800 to 9525.1930.

Subd. 2. **Vendor participation and reimbursement.** Notwithstanding requirements in chapters 245A and 245D, and sections 252.28, 252.41 to 252.46, and 256B.501, vendors of day training and habilitation services may enter into written agreements with qualified businesses to provide additional training and supervision needed by individuals to maintain their employment.

Subd. 3. **Agreement specifications.** Agreements must include the following:

(1) the type and amount of supervision and support to be provided by the business to the individual in accordance with their needs as identified in their individual service plan;

(2) the methods used to periodically assess the individual's satisfaction with their work, training, and support;

(3) the measures taken by the qualified business and the vendor to ensure the health, safety, and protection of the individual during working hours, including the reporting of abuse and neglect under state law and rules;

(4) the training and support services the vendor will provide to the qualified business, including the frequency of on-site supervision and support; and

(5) any payment to be made to the qualified business by the vendor. Payment to the business must be limited to:

(i) additional costs of training coworkers and managers that exceed ordinary and customary training costs and are a direct result of employing a person with a developmental disability; and

(ii) additional costs for training, supervising, and assisting the person with a developmental disability that exceed normal and customary costs required for performing similar tasks or duties.

Payments made to a qualified business under this section must not include incentive payments to the qualified business or salary supplementation for the person with a developmental disability.

Subd. 4. **Client protection.** Persons receiving training and support under this section may not be denied their rights or procedural protections under section 256.045, subdivision 4a, or 256B.092, including the county agency's responsibility to arrange for appropriate services, as necessary, in the event that persons lose their job or the contract with the qualified business is terminated.

Subd. 5. **Vendor payment.** (a) For purposes of this section, the vendor shall bill and the commissioner shall reimburse the vendor for full-day or partial-day services to a client that would otherwise have been paid to the vendor for providing direct services, provided that both of the following criteria are met:

(1) the vendor provides services and payments to the qualified business that enable the business to perform support and supervision services for the client that the vendor would otherwise need to perform; and

(2) the client for whom a rate will be billed will receive full-day or partial-day services from the vendor and the rate to be paid the vendor will allow the client to work with this support and supervision at the qualified business instead of receiving these services from the vendor.

(b) Medical assistance reimbursement of services provided to persons receiving day training and habilitation services under this section is subject to the limitations on reimbursement for vocational services under federal law and regulation.

254B.03 RESPONSIBILITY TO PROVIDE CHEMICAL DEPENDENCY TREATMENT.

Subd. 4a. **Division of costs for medical assistance services.** Notwithstanding subdivision 4, for chemical dependency services provided on or after October 1, 2008, and reimbursed by medical assistance, the county share is 30 percent of the nonfederal share.

256B.0615 MENTAL HEALTH CERTIFIED PEER SPECIALIST.

Subd. 2. **Establishment.** The commissioner of human services shall establish a certified peer specialist program model, which:

(1) provides nonclinical peer support counseling by certified peer specialists;

(2) provides a part of a wraparound continuum of services in conjunction with other community mental health services;

(3) is individualized to the consumer; and

(4) promotes socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.

Subd. 4. **Peer support specialist program providers.** The commissioner shall develop a process to certify peer support specialist programs, in accordance with the federal guidelines, in order for the program to bill for reimbursable services. Peer support programs may be freestanding or within existing mental health community provider centers.

Subd. 5. **Certified peer specialist training and certification.** The commissioner of human services shall develop a training and certification process for certified peer specialists, who must be at least 21 years of age. The candidates must have had a primary diagnosis of mental illness, be a current or former consumer of mental health services, and must demonstrate leadership and advocacy skills and a strong dedication to recovery. The training curriculum must teach participating consumers specific skills relevant to providing peer support to other consumers. In addition to initial training and certification, the commissioner shall develop ongoing continuing educational workshops on pertinent issues related to peer support counseling.

256B.0616 MENTAL HEALTH CERTIFIED FAMILY PEER SPECIALIST.

Subd. 2. **Establishment.** The commissioner of human services shall establish a certified family peer specialists program model which:

(1) provides nonclinical family peer support counseling, building on the strengths of families and helping them achieve desired outcomes;

(2) collaborates with others providing care or support to the family;

(3) provides nonadversarial advocacy;

(4) promotes the individual family culture in the treatment milieu;

(5) links parents to other parents in the community;

(6) offers support and encouragement;

(7) assists parents in developing coping mechanisms and problem-solving skills;

(8) promotes resiliency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services;

(9) establishes and provides peer-led parent support groups; and

(10) increases the child's ability to function better within the child's home, school, and community by educating parents on community resources, assisting with problem solving, and educating parents on mental illnesses.

Subd. 4. **Peer support specialist program providers.** The commissioner shall develop a process to certify family peer support specialist programs, in accordance with the federal guidelines, in order for the program to bill for reimbursable services. Family peer support programs must operate within an existing mental health community provider or center.

Subd. 5. **Certified family peer specialist training and certification.** The commissioner shall develop a training and certification process for certified family peer specialists who must be at least 21 years of age. The candidates must have raised or be currently raising a child with a mental illness, have had experience navigating the children's mental health system, and must demonstrate leadership and advocacy skills and a strong dedication to family-driven and family-focused services. The training curriculum must teach participating family peer specialists specific skills relevant to providing peer support to other parents. In addition to initial training and certification, the commissioner shall develop ongoing continuing educational workshops on pertinent issues related to family peer support counseling.

256B.0659 PERSONAL CARE ASSISTANCE PROGRAM.

Subd. 22. **Annual review for personal care providers.** (a) All personal care assistance provider agencies shall resubmit, on an annual basis, the information specified in subdivision 21, in a format determined by the commissioner, and provide a copy of the personal care assistance provider agency's most current version of its grievance policies and procedures along with a written record of grievances and resolutions of the grievances that the personal care assistance provider agency has received in the previous year and any other information requested by the commissioner.

(b) The commissioner shall send annual review notification to personal care assistance provider agencies 30 days prior to renewal. The notification must:

(1) list the materials and information the personal care assistance provider agency is required to submit;

(2) provide instructions on submitting information to the commissioner; and

(3) provide a due date by which the commissioner must receive the requested information.

Personal care assistance provider agencies shall submit required documentation for annual review within 30 days of notification from the commissioner. If no documentation is submitted, the personal care assistance provider agency enrollment number must be terminated or suspended.

(c) Personal care assistance provider agencies also currently licensed under section 144A.471, subdivision 6 or 7, or currently certified for participation in Medicare as a home health agency are deemed in compliance with the personal care assistance requirements for enrollment, annual review process, and documentation.

256B.0705 PERSONAL CARE ASSISTANCE SERVICES; MANDATED SERVICE VERIFICATION.

Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have the meanings given them.

(b) "Personal care assistance services" or "PCA services" means services provided according to section 256B.0659.

(c) "Personal care assistant" or "PCA" has the meaning given in section 256B.0659, subdivision 1.

(d) "Service verification" means a random, unscheduled telephone call made for the purpose of verifying that the individual personal care assistant is present at the location where personal care assistance services are being provided and is providing services as scheduled.

Subd. 2. **Verification schedule.** An agency that submits claims for reimbursement for PCA services under this chapter must develop and implement administrative policies and procedures by which the agency verifies the services provided by a PCA. For each service recipient, the agency must conduct at least one service verification every 90 days. If more than one PCA provides services to a single service recipient, the agency must conduct a service verification for each PCA providing services before conducting a service verification for a PCA whose services were previously verified by the agency. Service verification must occur on an ongoing basis while the agency provides PCA services to the recipient. During service verification, the agency must speak with both the PCA and the service recipient or recipient's authorized representative. Only qualified professional service verifications are eligible for reimbursement. An agency may substitute a visit by a qualified professional that is eligible for reimbursement under section 256B.0659, subdivision 14 or 19.

Subd. 3. **Documentation of verification.** An agency must fully document service verifications in a legible manner and must maintain the documentation on site for at least five years from the date of documentation. For each service verification, documentation must include:

(1) the names and signatures of the service recipient or recipient's authorized representative, the PCA and any other agency staff present with the PCA during the service verification, and the staff person conducting the service verification; and

(2) the start and end time, day, month, and year of the service verification, and the corresponding PCA time sheet.

Subd. 4. **Variance.** The Office of Inspector General at the Department of Human Services may grant a variance to the service verification requirements in this section if an agency uses an electronic monitoring system or other methods that verify a PCA is present at the location where services are provided and is providing services according to the prescribed schedule. A decision to grant or deny a variance request is final and not subject to appeal under chapter 14.

256B.0943 CHILDREN'S THERAPEUTIC SERVICES AND SUPPORTS.

Subd. 10. **Service authorization.** Children's therapeutic services and supports are subject to authorization criteria and standards published by the commissioner according to section 256B.0625, subdivision 25.

256B.0944 CHILDREN'S MENTAL HEALTH CRISIS RESPONSE SERVICES.

Subd. 10. **Client record.** The provider must maintain a file for each client that complies with the requirements under section 256B.0943, subdivision 11, and contains the following information:

(1) individual crisis treatment plans signed by the recipient, mental health professional, and mental health practitioner who developed the crisis treatment plan, or if the recipient refused to sign the plan, the date and reason stated by the recipient for not signing the plan;

(2) signed release of information forms;

(3) recipient health information and current medications;

(4) emergency contacts for the recipient;

(5) case records that document the date of service, place of service delivery, signature of the person providing the service, and the nature, extent, and units of service. Direct or telephone contact with the recipient's family or others should be documented;

(6) required clinical supervision by mental health professionals;

(7) summary of the recipient's case reviews by staff; and

(8) any written information by the recipient that the recipient wants in the file.

256B.0946 INTENSIVE TREATMENT IN FOSTER CARE.

Subd. 5. **Service authorization.** The commissioner will administer authorizations for services under this section in compliance with section 256B.0625, subdivision 25.

256B.0947 INTENSIVE REHABILITATIVE MENTAL HEALTH SERVICES.

Subd. 9. **Service authorization.** The commissioner shall publish prior authorization criteria and standards to be used for intensive nonresidential rehabilitative mental health services, as provided in section 256B.0625, subdivision 25.

256B.431 RATE DETERMINATION.

Subd. 3a. **Property-related costs after July 1, 1985.** (a) For rate years beginning on or after July 1, 1985, the commissioner, by permanent rule, shall reimburse nursing facility providers that are vendors in the medical assistance program for the rental use of real estate and depreciable equipment. "Real estate" means land improvements, buildings, and attached fixtures used directly for resident care. "Depreciable equipment" means the standard movable resident care equipment and support service equipment generally used in long-term care facilities.

(b) In developing the method for determining payment rates for the rental use of nursing facilities, the commissioner shall consider factors designed to:

(1) simplify the administrative procedures for determining payment rates for property-related costs;

(2) minimize discretionary or appealable decisions;

(3) eliminate any incentives to sell nursing facilities;

(4) recognize legitimate costs of preserving and replacing property;

(5) recognize the existing costs of outstanding indebtedness allowable under the statutes and rules in effect on May 1, 1983;

(6) address the current value of, if used directly for patient care, land improvements, buildings, attached fixtures, and equipment;

(7) establish an investment per bed limitation;

(8) reward efficient management of capital assets;

(9) provide equitable treatment of facilities;

(10) consider a variable rate; and

(11) phase-in implementation of the rental reimbursement method.

(c) For rate years beginning on or after July 1, 1987, a nursing facility which has reduced licensed bed capacity after January 1, 1986, shall be allowed to:

(1) aggregate the applicable investment per bed limits based on the number of beds licensed prior to the reduction; and

(2) establish capacity days for each rate year following the licensure reduction based on the number of beds licensed on the previous April 1 if the commissioner is notified of the change by April 4. The notification must include a copy of the delicensure request that has been submitted to the commissioner of health.

(d) For rate years beginning on or after July 1, 1989, the interest expense that results from a refinancing of a nursing facility's demand call loan, when the loan that must be refinanced was incurred before May 22, 1983, is an allowable interest expense if:

(1) the demand call loan or any part of it was in the form of a loan that was callable at the demand of the lender;

(2) the demand call loan or any part of it was called by the lender through no fault of the nursing facility;

(3) the demand call loan or any part of it was made by a government agency operating under a statutory or regulatory loan program;

(4) the refinanced debt does not exceed the sum of the allowable remaining balance of the demand call loan at the time of payment on the demand call loan and refinancing costs;

(5) the term of the refinanced debt does not exceed the remaining term of the demand call loan, had the debt not been subject to an on-call payment demand; and

(6) the refinanced debt is not a debt between related organizations as defined in Minnesota Rules, part 9549.0020, subpart 38.

Subd. 3f. **Property costs after July 1, 1988.** (a) For the rate year beginning July 1, 1988, the replacement-cost-new per bed limit must be $32,571 per licensed bed in multiple bedrooms and $48,857 per licensed bed in a single bedroom. For the rate year beginning July 1, 1989, the replacement-cost-new per bed limit for a single bedroom must be $49,907 adjusted according to Minnesota Rules, part 9549.0060, subpart 4, item A, subitem (1). Beginning January 1, 1990, the replacement-cost-new per bed limits must be adjusted annually as specified in Minnesota Rules, part 9549.0060, subpart 4, item A, subitem (1). Beginning January 1, 1991, the replacement-cost-new per bed limits will be adjusted annually as specified in Minnesota Rules, part 9549.0060, subpart 4, item A, subitem (1), except that the index utilized will be the Bureau of Economic Analysis: Price Indexes for Private Fixed Investments in Structures; Special Care.

(b) For the rate year beginning July 1, 1988, the commissioner shall increase the rental factor as established in Minnesota Rules, part 9549.0060, subpart 8, item A, by 6.2 percent rounded to the nearest 100th percent for the purpose of reimbursing nursing facilities for soft costs and entrepreneurial profits not included in the cost valuation services used by the state's contracted appraisers. For rate years beginning on or after July 1, 1989, the rental factor is the amount determined under this paragraph for the rate year beginning July 1, 1988.

(c) For rate years beginning on or after July 1, 1988, in order to determine property-related payment rates under Minnesota Rules, part 9549.0060, for all nursing facilities except those whose average length of stay in a skilled level of care within a nursing facility is 180 days or less, the commissioner shall use 95 percent of capacity days. For a nursing facility whose average length of stay in a skilled level of care within a nursing facility is 180 days or less, the commissioner shall use the greater of resident days or 80 percent of capacity days but in no event shall the divisor exceed 95 percent of capacity days.

(d) For rate years beginning on July 1, 1988, and July 1, 1989, the commissioner shall add ten cents per resident per day to each nursing facility's property-related payment rate. The ten-cent property-related payment rate increase is not cumulative from rate year to rate year. For the rate year beginning July 1, 1990, the commissioner shall increase each nursing facility's equipment allowance as established in Minnesota Rules, part 9549.0060, subpart 10, by ten cents per resident per day. For rate years beginning on or after July 1, 1991, the adjusted equipment allowance must be adjusted annually for inflation as in Minnesota Rules, part 9549.0060, subpart 10, item E. For the rate period beginning October 1, 1992, the equipment allowance for each nursing facility shall be increased by 28 percent. For rate years beginning after June 30, 1993, the allowance must be adjusted annually for inflation.

(e) For rate years beginning on or after July 1, 1990, Minnesota Rules, part 9549.0060, subpart 5, item E, shall not apply to outstanding related organization debt incurred prior to May 23, 1983, provided that the debt was an allowable debt under Minnesota Rules, parts 9510.0010 to 9510.0480, the debt is subject to repayment through annual principal payments, and the nursing facility demonstrates to the commissioner's satisfaction that the interest rate on the debt was less than market interest rates for similar arm's-length transactions at the time the debt was incurred. If the debt was incurred due to a sale between family members, the nursing facility must also demonstrate that the seller no longer participates in the management or operation of the nursing facility. Debts meeting the conditions of this paragraph are subject to all other provisions of Minnesota Rules, parts 9549.0010 to 9549.0080.

(f) For rate years beginning on or after July 1, 1990, a nursing facility with operating lease costs incurred for the nursing facility's buildings shall receive its building capital allowance computed in accordance with Minnesota Rules, part 9549.0060, subpart 8. If an operating lease provides that the lessee's rent is adjusted to recognize improvements made by the lessor and related debt, the costs for capital improvements and related debt shall be allowed in the computation of the lessee's building capital allowance, provided that reimbursement for these costs under an operating lease shall not exceed the rate otherwise paid.

Subd. 3g. **Property costs after July 1, 1990, for certain facilities.** (a) For rate years beginning on or after July 1, 1990, nursing facilities that, on or after January 1, 1976, but prior to January 1, 1987, were newly licensed after new construction, or increased their licensed beds by a minimum of 35 percent through new construction, and whose building capital allowance is less than their allowable annual principal and interest on allowable debt prior to the application of the replacement-cost-new per bed limit and whose remaining weighted average debt amortization schedule as of January 1, 1988, exceeded 15 years, must receive a property-related payment rate equal to the greater of their rental per diem or their annual allowable principal and allowable interest without application of the replacement-cost-new per bed limit, divided by their capacity days as determined under Minnesota Rules, part 9549.0060, subpart 11, as modified by subdivision 3f, paragraph (c), for the preceding reporting year, plus their equipment allowance. A nursing facility that is eligible for a property-related payment rate under this subdivision and whose property-related payment rate in a subsequent rate year is its rental per diem must continue to have its property-related payment rates established for all future rate years based on the rental reimbursement method in Minnesota Rules, part 9549.0060.

The commissioner may require the nursing facility to apply for refinancing as a condition of receiving special rate treatment under this subdivision.

(b) If a nursing facility is eligible for a property-related payment rate under this subdivision, and the nursing facility's debt is refinanced after October 1, 1988, the provisions in paragraphs (1) to (7) also apply to the property-related payment rate for rate years beginning on or after July 1, 1990.

(1) A nursing facility's refinancing must not include debts with balloon payments.

(2) If the issuance costs, including issuance costs on the debt refinanced, are financed as part of the refinancing, the historical cost of capital assets limit in Minnesota Rules, part 9549.0060, subpart 5, item A, subitem (6), includes issuance costs that do not exceed seven percent of the debt refinanced, plus the related issuance costs. For purposes of this paragraph, issuance costs means the fees charged by the underwriter, issuer, attorneys, bond raters, appraisers, and trustees, and includes the cost of printing, title insurance, registration tax, and a feasibility study for the refinancing of a nursing facility's debt. Issuance costs do not include bond premiums or discounts when bonds are sold at other than their par value, points, or a bond reserve fund. To the extent otherwise allowed under this paragraph, the straight-line amortization of the refinancing issuance costs is not an allowable cost.

(3) The annual principal and interest expense payments and any required annual municipal fees on the nursing facility's refinancing replace those of the refinanced debt and, together with annual principal and interest payments on other allowable debts, are allowable costs subject to the limitation on historical cost of capital assets plus issuance costs as limited in paragraph (2), if any.

(4) If the nursing facility's refinancing includes zero coupon bonds, the commissioner shall establish a monthly debt service payment schedule based on an annuity that will produce an amount equal to the zero coupon bonds at maturity. The term and interest rate is the term and interest rate of the zero coupon bonds. Any refinancing to repay the zero coupon bonds is not an allowable cost.

(5) The annual amount of annuity payments is added to the nursing facility's allowable annual principal and interest payment computed in paragraph (3).

(6) The property-related payment rate is equal to the amount in paragraph (5), divided by the nursing facility's capacity days as determined under Minnesota Rules, part 9549.0060, subpart 11, as modified by subdivision 3f, paragraph (c), for the preceding reporting year plus an equipment allowance.

(7) Except as provided in this subdivision, the provisions of Minnesota Rules, part 9549.0060 apply.

Subd. 3i. **Property costs for the rate year beginning July 1, 1990.** Notwithstanding Minnesota Rules, part 9549.0060, subpart 13, item H, the commissioner shall determine property-related payment rates for nursing facilities for the rate year beginning July 1, 1990, as follows:

(a) The property-related payment rate for a nursing facility that qualifies under subdivision 3g is the greater of the rate determined under that subdivision or the rate determined under paragraph (c), (d), or (e), whichever is applicable.

(b) Nursing facilities shall be grouped according to the type of property-related payment rate the commissioner determined for the rate year beginning July 1, 1989. A nursing facility whose

property-related payment rate was determined under Minnesota Rules, part 9549.0060, subpart 13, item A (full rental reimbursement), shall be considered group A. A nursing facility whose property-related payment rate was determined under Minnesota Rules, part 9549.0060, subpart 13, item B (phase-down to full rental reimbursement), shall be considered group B. A nursing facility whose property-related payment rate was determined under Minnesota Rules, part 9549.0060, subpart 13, item C or D (phase-up to full rental reimbursement), shall be considered group C.

(c) For the rate year beginning July 1, 1990, a group A nursing facility shall receive its property-related payment rate determined under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section.

(d) For the rate year beginning July 1, 1990, a Group B nursing facility shall receive the greater of 87 percent of the property-related payment rate in effect on July 1, 1989; or the rental per diem rate determined under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section in effect on July 1, 1990; or the sum of 100 percent of the nursing facility's allowable principal and interest expense, plus its equipment allowance multiplied by the resident days for the reporting year ending September 30, 1989, divided by the nursing facility's capacity days as determined under Minnesota Rules, part 9549.0060, subpart 11, as modified by subdivision 3f, paragraph (c); except that the nursing facility's property-related payment rate must not exceed its property-related payment rate in effect on July 1, 1989.

(e) For the rate year beginning July 1, 1990, a group C nursing facility shall receive its property-related payment rate determined under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section, except the rate must not exceed the lesser of its property-related payment rate determined for the rate year beginning July 1, 1989, multiplied by 116 percent or its rental per diem rate determined effective July 1, 1990.

(f) The property-related payment rate for a nursing facility that qualifies for a rate adjustment under Minnesota Rules, part 9549.0060, subpart 13, item G (special reappraisals), shall have the property-related payment rate determined in paragraphs (a) to (e) adjusted according to the provisions in that rule.

(g) Except as provided in subdivision 4, paragraph (f), and subdivision 11, a nursing facility that has a change in ownership or a reorganization of provider entity is subject to the provisions of Minnesota Rules, part 9549.0060, subpart 13, item F.

Subd. 13. **Hold-harmless property-related rates.** (a) Terms used in subdivisions 13 to 21 shall be as defined in Minnesota Rules, parts 9549.0010 to 9549.0080, and this section.

(b) Except as provided in this subdivision, for rate periods beginning on October 1, 1992, and for rate years beginning after June 30, 1993, the property-related rate for a nursing facility shall be the greater of $4 or the property-related payment rate in effect on September 30, 1992. In addition, the incremental increase in the nursing facility's rental rate will be determined under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section.

(c) Notwithstanding Minnesota Rules, part 9549.0060, subpart 13, item F, a nursing facility that has a sale permitted under subdivision 14 after June 30, 1992, shall receive the property-related payment rate in effect at the time of the sale or reorganization. For rate periods beginning after October 1, 1992, and for rate years beginning after June 30, 1993, a nursing facility shall receive, in addition to its property-related payment rate in effect at the time of the sale, the incremental increase allowed under subdivision 14.

(d) For rate years beginning after June 30, 1993, the property-related rate for a nursing facility licensed after July 1, 1989, after relocating its beds from a separate nursing home to a building formerly used as a hospital and sold during the cost reporting year ending September 30, 1991, shall be its property-related rate prior to the sale in addition to the incremental increases provided under this section effective on October 1, 1992, of 29 cents per day, and any incremental increases after October 1, 1992, calculated by using its rental rate under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section, recognizing the current appraised value of the facility at the new location, and including as allowable debt otherwise allowable debt incurred to remodel the facility in the new location prior to the relocation of beds.

Subd. 15. **Capital repair and replacement cost reporting and rate calculation.** For rate years beginning after June 30, 1993, a nursing facility's capital repair and replacement payment rate shall be established annually as provided in paragraphs (a) to (e).

(a) Notwithstanding Minnesota Rules, part 9549.0060, subpart 12, the costs of any of the following items not included in the equity incentive computations under subdivision 16 or reported

as a capital asset addition under subdivision 18, paragraph (b), including cash payment for equity investment and principal and interest expense for debt financing, must be reported in the capital repair and replacement cost category:

(1) wall coverings;

(2) paint;

(3) floor coverings;

(4) window coverings;

(5) roof repair; and

(6) window repair or replacement.

(b) Notwithstanding Minnesota Rules, part 9549.0060, subpart 12, the repair or replacement of a capital asset not included in the equity incentive computations under subdivision 16 or reported as a capital asset addition under subdivision 18, paragraph (b), must be reported under this subdivision when the cost of the item exceeds $500, or in the plant operations and maintenance cost category when the cost of the item is equal to or less than $500.

(c) To compute the capital repair and replacement payment rate, the allowable annual repair and replacement costs for the reporting year must be divided by actual resident days for the reporting year. The annual allowable capital repair and replacement costs shall not exceed $150 per licensed bed. The excess of the allowed capital repair and replacement costs over the capital repair and replacement limit shall be a cost carryover to succeeding cost reporting periods, except that sale of a facility, under subdivision 14, shall terminate the carryover of all costs except those incurred in the most recent cost reporting year. The termination of the carryover shall have effect on the capital repair and replacement rate on the same date as provided in subdivision 14, paragraph (f), for the sale. For rate years beginning after June 30, 1994, the capital repair and replacement limit shall be subject to the index provided in subdivision 3f, paragraph (a). For purposes of this subdivision, the number of licensed beds shall be the number used to calculate the nursing facility's capacity days. The capital repair and replacement rate must be added to the nursing facility's total payment rate.

(d) Capital repair and replacement costs under this subdivision shall not be counted as either care-related or other operating costs, nor subject to care-related or other operating limits.

(e) If costs otherwise allowable under this subdivision are incurred as the result of a project approved under the moratorium exception process in section 144A.073, or in connection with an addition to or replacement of buildings, attached fixtures, or land improvements for which the total historical cost of these assets exceeds the lesser of $150,000 or ten percent of the nursing facility's appraised value, these costs must be claimed under subdivision 16 or 17, as appropriate.

Subd. 17. **Special provisions for moratorium exceptions.** Notwithstanding Minnesota Rules, part 9549.0060, subpart 3, for rate periods beginning on October 1, 1992, and for rate years beginning after June 30, 1993, a nursing facility that (1) has completed a construction project approved under section 144A.071, subdivision 4a, clause (m); (2) has completed a construction project approved under section 144A.071, subdivision 4a, and effective after June 30, 1995; (3) has completed a construction project approved under section 144A.071, subdivision 4c; or (4) has completed a renovation, replacement, or upgrading project approved under the moratorium exception process in section 144A.073 shall be reimbursed for costs directly identified to that project as provided in subdivision 16 and subdivisions 17 to 17f.

Subd. 17a. **Allowable interest expense.** (a) Notwithstanding Minnesota Rules, part 9549.0060, subparts 5, item A, subitems (1) and (3), and 7, item D, allowable interest expense on debt shall include:

(1) interest expense on debt related to the cost of purchasing or replacing depreciable equipment, excluding vehicles, not to exceed ten percent of the total historical cost of the project; and

(2) interest expense on debt related to financing or refinancing costs, including costs related to points, loan origination fees, financing charges, legal fees, and title searches; and issuance costs including bond discounts, bond counsel, underwriter's counsel, corporate counsel, printing, and financial forecasts. Allowable debt related to items in this clause shall not exceed seven percent of the total historical cost of the project. To the extent these costs are financed, the straight-line amortization of the costs in this clause is not an allowable cost; and

(3) interest on debt incurred for the establishment of a debt reserve fund, net of the interest earned on the debt reserve fund.

(b) Debt incurred for costs under paragraph (a) is not subject to Minnesota Rules, part 9549.0060, subpart 5, item A, subitem (5) or (6).

Subd. 17c. **Replacement-costs-new per bed limit.** Notwithstanding subdivision 3f, paragraph (a), for rate periods beginning on October 1, 1992, and for rate years beginning after June 30, 1993, the replacement-costs-new per bed limit to be used in Minnesota Rules, part 9549.0060, subpart 4, item B, for a nursing facility that has completed a renovation, replacement, or upgrading project that has been approved under the moratorium exception process in section 144A.073, or that has completed an addition to or replacement of buildings, attached fixtures, or land improvements for which the total historical cost exceeds the lesser of $150,000 or ten percent of the most recent appraised value, must be $47,500 per licensed bed in multiple-bed rooms and $71,250 per licensed bed in a single-bed room. These amounts must be adjusted annually as specified in subdivision 3f, paragraph (a), beginning January 1, 1993.

Subd. 17d. **Determination of rental per diem for total replacement projects.** (a) For purposes of this subdivision, a total replacement means the complete replacement of the nursing facility's physical plant through the construction of a new physical plant, the transfer of the nursing facility's license from one physical plant location to another, or a new building addition to relocate beds from three- and four-bed wards. For total replacement projects completed on or after July 1, 1992, the commissioner shall compute the incremental change in the nursing facility's rental per diem, for rate years beginning on or after July 1, 1995, by replacing its appraised value, including the historical capital asset costs, and the capital debt and interest costs with the new nursing facility's allowable capital asset costs and the related allowable capital debt and interest costs. If the new nursing facility has decreased its licensed capacity, the aggregate investment per bed limit in subdivision 3a, paragraph (c), shall apply.

(b) If the new nursing facility has retained a portion of the original physical plant for nursing facility usage, then a portion of the appraised value prior to the replacement must be retained and included in the calculation of the incremental change in the nursing facility's rental per diem. For purposes of this subdivision, the original nursing facility means the nursing facility prior to the total replacement project. The portion of the appraised value to be retained shall be calculated according to clauses (1) to (3):

(1) The numerator of the allocation ratio shall be the square footage of the area in the original physical plant which is being retained for nursing facility usage.

(2) The denominator of the allocation ratio shall be the total square footage of the original nursing facility physical plant.

(3) Each component of the nursing facility's allowable appraised value prior to the total replacement project shall be multiplied by the allocation ratio developed by dividing clause (1) by clause (2).

(c) In the case of either type of total replacement as authorized under section 144A.071 or 144A.073, the provisions of subdivisions 17 to 17f shall also apply.

(d) For purposes of the moratorium exception authorized under section 144A.071, subdivision 4a, paragraph (s), if the total replacement involves the renovation and use of an existing health care facility physical plant, the new allowable capital asset costs and related debt and interest costs shall include first the allowable capital asset costs and related debt and interest costs of the renovation, to which shall be added the allowable capital asset costs of the existing physical plant prior to the renovation, and if reported by the facility, the related allowable capital debt and interest costs.

Subd. 17e. **Replacement-costs-new per bed limit effective October 1, 2007.** Notwithstanding Minnesota Rules, part 9549.0060, subpart 11, item C, subitem (2), for a total replacement, as defined in subdivision 17d, authorized under section 144A.071 or 144A.073 after July 1, 1999, any building project that is a relocation, renovation, upgrading, or conversion completed on or after July 1, 2001, or any building project eligible for reimbursement under section 256B.434, subdivision 4f, the replacement-costs-new per bed limit shall be $74,280 per licensed bed in multiple-bed rooms, $92,850 per licensed bed in semiprivate rooms with a fixed partition separating the resident beds, and $111,420 per licensed bed in single rooms. Minnesota Rules, part 9549.0060, subpart 11, item C, subitem (2), does not apply. These amounts must be adjusted annually as specified in subdivision 3f, paragraph (a), beginning January 1, 2000. These amounts must be increased annually as specified in subdivision 3f, paragraph (a), beginning October 1, 2012.

Subd. 18. **Updating appraisals, additions, and replacements.** (a) Notwithstanding Minnesota Rules, part 9549.0060, subparts 1 to 3, the appraised value, routine updating of the appraised value, and special reappraisals are subject to this subdivision.

For all rate years after June 30, 1993, the commissioner shall no longer conduct any appraisals under Minnesota Rules, part 9549.0060, for the purpose of determining property-related payment rates.

(b) Notwithstanding Minnesota Rules, part 9549.0060, subpart 2, for rate years beginning after June 30, 1993, the commissioner shall routinely update the appraised value of each nursing facility by adding the cost of capital asset acquisitions to its allowable appraised value.

The commissioner shall also annually index each nursing facility's allowable appraised value by the inflation index referenced in subdivision 3f, paragraph (a), for the purpose of computing the nursing facility's annual rental rate. In annually adjusting the nursing facility's appraised value, the commissioner must not include the historical cost of capital assets acquired during the reporting year in the nursing facility's appraised value.

In addition, the nursing facility's appraised value must be reduced by the historical cost of capital asset disposals or applicable credits such as public grants and insurance proceeds. Capital asset additions and disposals must be reported on the nursing facility's annual cost report in the reporting year of acquisition or disposal. The incremental increase in the nursing facility's rental rate resulting from this annual adjustment as determined under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section shall be added to the nursing facility's property-related payment rate for the rate year following the reporting year.

Subd. 21. **Indexing thresholds.** Beginning January 1, 1993, and each January 1 thereafter, the commissioner shall annually update the dollar thresholds in subdivisions 15, paragraph (e), 16, and 17, and in section 144A.071, subdivisions 2 and 4a, clauses (b) and (e), by the inflation index referenced in subdivision 3f, paragraph (a).

Subd. 22. **Changes to nursing facility reimbursement.** In the determination of incremental increases in the nursing facility's rental rate as required in subdivisions 14 to 21, except for a refinancing permitted under subdivision 19, the commissioner must adjust the nursing facility's property-related payment rate for both incremental increases and decreases in recomputations of its rental rate.

Subd. 30. **Bed layaway and delicensure.** (a) For rate years beginning on or after July 1, 2000, a nursing facility reimbursed under this section which has placed beds on layaway shall, for purposes of application of the downsizing incentive in subdivision 3a, paragraph (c), and calculation of the rental per diem, have those beds given the same effect as if the beds had been delicensed so long as the beds remain on layaway. At the time of a layaway, a facility may change its single bed election for use in calculating capacity days under Minnesota Rules, part 9549.0060, subpart 11. The property payment rate increase shall be effective the first day of the month of January or July, whichever occurs first following the date on which the layaway of the beds becomes effective under section 144A.071, subdivision 4b.

(b) For rate years beginning on or after July 1, 2000, notwithstanding any provision to the contrary under section 256B.434 or chapter 256R, a nursing facility reimbursed under that section or chapter that has placed beds on layaway shall, for so long as the beds remain on layaway, be allowed to:

(1) aggregate the applicable investment per bed limits based on the number of beds licensed immediately prior to entering the alternative payment system;

(2) retain or change the facility's single bed election for use in calculating capacity days under Minnesota Rules, part 9549.0060, subpart 11; and

(3) establish capacity days based on the number of beds immediately prior to the layaway and the number of beds after the layaway.

The commissioner shall increase the facility's property payment rate by the incremental increase in the rental per diem resulting from the recalculation of the facility's rental per diem applying only the changes resulting from the layaway of beds and clauses (1), (2), and (3). If a facility reimbursed under section 256B.434 or chapter 256R completes a moratorium exception project after its base year, the base year property rate shall be the moratorium project property rate. The base year rate shall be inflated by the factors in section 256B.434, subdivision 4, paragraph (c). The property

payment rate increase shall be effective the first day of the month of January or July, whichever occurs first following the date on which the layaway of the beds becomes effective.

(c) If a nursing facility removes a bed from layaway status in accordance with section 144A.071, subdivision 4b, the commissioner shall establish capacity days based on the number of licensed and certified beds in the facility not on layaway and shall reduce the nursing facility's property payment rate in accordance with paragraph (b).

(d) For the rate years beginning on or after July 1, 2000, notwithstanding any provision to the contrary under section 256B.434 or chapter 256R, a nursing facility reimbursed under that section or chapter that has delicensed beds after July 1, 2000, by giving notice of the delicensure to the commissioner of health according to the notice requirements in section 144A.071, subdivision 4b, shall be allowed to:

(1) aggregate the applicable investment per bed limits based on the number of beds licensed immediately prior to entering the alternative payment system;

(2) retain or change the facility's single bed election for use in calculating capacity days under Minnesota Rules, part 9549.0060, subpart 11; and

(3) establish capacity days based on the number of beds immediately prior to the delicensure and the number of beds after the delicensure.

The commissioner shall increase the facility's property payment rate by the incremental increase in the rental per diem resulting from the recalculation of the facility's rental per diem applying only the changes resulting from the delicensure of beds and clauses (1), (2), and (3). If a facility reimbursed under section 256B.434 completes a moratorium exception project after its base year, the base year property rate shall be the moratorium project property rate. The base year rate shall be inflated by the factors in section 256B.434, subdivision 4, paragraph (c). The property payment rate increase shall be effective the first day of the month of January or July, whichever occurs first following the date on which the delicensure of the beds becomes effective.

(e) For nursing facilities reimbursed under this section, section 256B.434, or chapter 256R, any beds placed on layaway shall not be included in calculating facility occupancy as it pertains to leave days defined in Minnesota Rules, part 9505.0415.

(f) For nursing facilities reimbursed under this section, section 256B.434, or chapter 256R, the rental rate calculated after placing beds on layaway may not be less than the rental rate prior to placing beds on layaway.

(g) A nursing facility receiving a rate adjustment as a result of this section shall comply with section 256R.06, subdivision 5.

(h) A facility that does not utilize the space made available as a result of bed layaway or delicensure under this subdivision to reduce the number of beds per room or provide more common space for nursing facility uses or perform other activities related to the operation of the nursing facility shall have its property rate increase calculated under this subdivision reduced by the ratio of the square footage made available that is not used for these purposes to the total square footage made available as a result of bed layaway or delicensure.

Subd. 45. **Rate adjustments for some moratorium exception projects.** Notwithstanding any other law to the contrary, money available for moratorium exception projects under section 144A.073, subdivisions 2 and 11, shall be used to fund the incremental rate increases resulting from this section for any nursing facility with a moratorium exception project approved under section 144A.073, and completed after August 30, 2010, where the replacement-costs-new limits under subdivision 17e were higher at any time after project approval than at the time of project completion. The commissioner shall calculate the property rate increase for these facilities using the highest set of limits; however, any rate increase under this section shall not be effective until on or after the effective date of this section, contingent upon federal approval. No property rate decrease shall result from this section.

256B.434 ALTERNATIVE PAYMENT DEMONSTRATION PROJECT.

Subd. 4. **Alternate rates for nursing facilities.** Effective for the rate years beginning on and after January 1, 2019, a nursing facility's property payment rate for the second and subsequent years of a facility's contract under this section are the previous rate year's property payment rate plus an inflation adjustment. The index for the inflation adjustment must be based on the change in the Consumer Price Index-All Items (United States City average) (CPI-U) forecasted by the Reports and Forecasts Division of the Department of Human Services, as forecasted in the fourth quarter

of the calendar year preceding the rate year. The inflation adjustment must be based on the 12-month period from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined.

Subd. 4f. **Construction project rate adjustments effective October 1, 2006.** (a) Effective October 1, 2006, facilities reimbursed under this section may receive a property rate adjustment for construction projects exceeding the threshold in section 256B.431, subdivision 16, and below the threshold in section 144A.071, subdivision 2, clause (a). For these projects, capital assets purchased shall be counted as construction project costs for a rate adjustment request made by a facility if they are: (1) purchased within 24 months of the completion of the construction project; (2) purchased after the completion date of any prior construction project; and (3) are not purchased prior to July 14, 2005. Except as otherwise provided in this subdivision, the definitions, rate calculation methods, and principles in sections 144A.071 and 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080, shall be used to calculate rate adjustments for allowable construction projects under this subdivision and section 144A.073. Facilities completing construction projects between October 1, 2005, and October 1, 2006, are eligible to have a property rate adjustment effective October 1, 2006. Facilities completing projects after October 1, 2006, are eligible for a property rate adjustment effective on the first day of the month following the completion date. Facilities completing projects after January 1, 2018, are eligible for a property rate adjustment effective on the first day of the month of January or July, whichever occurs immediately following the completion date.

(b) Notwithstanding subdivision 18, as of July 14, 2005, facilities with rates set under section 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080, that commenced a construction project on or after October 1, 2004, and do not have a contract under subdivision 3 by September 30, 2006, are eligible to request a rate adjustment under section 256B.431, subdivision 10, through September 30, 2006. If the request results in the commissioner determining a rate adjustment is allowable, the rate adjustment is effective on the first of the month following project completion. These facilities shall be allowed to accumulate construction project costs for the period October 1, 2004, to September 30, 2006.

(c) Facilities shall be allowed construction project rate adjustments no sooner than 12 months after completing a previous construction project. Facilities must request the rate adjustment according to section 256B.431, subdivision 10.

(d) Capacity days shall be computed according to Minnesota Rules, part 9549.0060, subpart 11. For rate calculations under this section, the number of licensed beds in the nursing facility shall be the number existing after the construction project is completed and the number of days in the nursing facility's reporting period shall be 365.

(e) The value of assets to be recognized for a total replacement project as defined in section 256B.431, subdivision 17d, shall be computed as described in clause (1). The value of assets to be recognized for all other projects shall be computed as described in clause (2).

(1) Replacement-cost-new limits under section 256B.431, subdivision 17e, and the number of beds allowed under subdivision 3a, paragraph (c), shall be used to compute the maximum amount of assets allowable in a facility's property rate calculation. If a facility's current request for a rate adjustment results from the completion of a construction project that was previously approved under section 144A.073, the assets to be used in the rate calculation cannot exceed the lesser of the amount determined under sections 144A.071, subdivision 2, and 144A.073, subdivision 3b, or the actual allowable costs of the construction project. A current request that is not the result of a project under section 144A.073 cannot exceed the limit under section 144A.071, subdivision 2, paragraph (a). Applicable credits must be deducted from the cost of the construction project.

(2)(i) Replacement-cost-new limits under section 256B.431, subdivision 17e, and the number of beds allowed under section 256B.431, subdivision 3a, paragraph (c), shall be used to compute the maximum amount of assets allowable in a facility's property rate calculation.

(ii) The value of a facility's assets to be compared to the amount in item (i) begins with the total appraised value from the last rate notice a facility received when its rates were set under section 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080. This value shall be indexed by the factor in section 256B.431, subdivision 3f, paragraph (a), for each rate year the facility received an inflation factor on its property-related rate when its rates were set under this section. The value of assets listed as previous capital additions, capital additions, and special projects on the facility's base year rate notice and the value of assets related to a construction project for which the facility

received a rate adjustment when its rates were determined under this section shall be added to the indexed appraised value.

(iii) The maximum amount of assets to be recognized in computing a facility's rate adjustment after a project is completed is the lesser of the aggregate replacement-cost-new limit computed in (i) minus the assets recognized in (ii) or the actual allowable costs of the construction project.

(iv) If a facility's current request for a rate adjustment results from the completion of a construction project that was previously approved under section 144A.073, the assets to be added to the rate calculation cannot exceed the lesser of the amount determined under sections 144A.071, subdivision 2, and 144A.073, subdivision 3b, or the actual allowable costs of the construction project. A current request that is not the result of a project under section 144A.073 cannot exceed the limit stated in section 144A.071, subdivision 2, paragraph (a). Assets disposed of as a result of a construction project and applicable credits must be deducted from the cost of the construction project.

(f) For construction projects approved under section 144A.073, allowable debt may never exceed the lesser of the cost of the assets purchased, the threshold limit in section 144A.071, subdivision 2, or the replacement-cost-new limit less previously existing capital debt.

(g) For construction projects that were not approved under section 144A.073, allowable debt is limited to the lesser of the threshold in section 144A.071, subdivision 2, for such construction projects or the applicable limit in paragraph (e), clause (1) or (2), less previously existing capital debt. Amounts of debt taken out that exceed the costs of a construction project shall not be allowed regardless of the use of the funds.

For all construction projects being recognized, interest expense and average debt shall be computed based on the first 12 months following project completion. "Previously existing capital debt" means capital debt recognized on the last rate determined under section 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080, and the amount of debt recognized for a construction project for which the facility received a rate adjustment when its rates were determined under this section.

For a total replacement project as defined in section 256B.431, subdivision 17d, the value of previously existing capital debt shall be zero.

(h) In addition to the interest expense allowed from the application of paragraph (f), the amounts allowed under section 256B.431, subdivision 17a, paragraph (a), clauses (2) and (3), will be added to interest expense.

(i) The equity portion of the construction project shall be computed as the allowable assets in paragraph (e), less the average debt in paragraph (f). The equity portion must be multiplied by 5.66 percent and the allowable interest expense in paragraph (f) must be added. This sum must be divided by 95 percent of capacity days to compute the construction project rate adjustment.

(j) For projects that are not a total replacement of a nursing facility, the amount in paragraph (i) is adjusted for nonreimbursable areas and then added to the current property payment rate of the facility.

(k) For projects that are a total replacement of a nursing facility, the amount in paragraph (i) becomes the new property payment rate after being adjusted for nonreimbursable areas. Any amounts existing in a facility's rate before the effective date of the construction project for equity incentives under section 256B.431, subdivision 16; capital repairs and replacements under section 256B.431, subdivision 15; or refinancing incentives under section 256B.431, subdivision 19, shall be removed from the facility's rates.

(l) No additional equipment allowance is allowed under Minnesota Rules, part 9549.0060, subpart 10, as the result of construction projects under this section. Allowable equipment shall be included in the construction project costs.

(m) Capital assets purchased after the completion date of a construction project shall be counted as construction project costs for any future rate adjustment request made by a facility under section 144A.071, subdivision 2, clause (a), if they are purchased within 24 months of the completion of the future construction project.

(n) In subsequent rate years, the property payment rate for a facility that results from the application of this subdivision shall be the amount inflated in subdivision 4.

(o) Construction projects are eligible for an equity incentive under section 256B.431, subdivision 16. When computing the equity incentive for a construction project under this subdivision, only the allowable costs and allowable debt related to the construction project shall be used. The equity incentive shall not be a part of the property payment rate and not inflated under subdivision 4. Effective October 1, 2006, all equity incentives for nursing facilities reimbursed under this section shall be allowed for a duration determined under section 256B.431, subdivision 16, paragraph (c).

Subd. 4i. **Construction project rate adjustments for certain nursing facilities.** (a) This subdivision applies to nursing facilities with at least 120 active beds as of January 1, 2015, that have projects approved in 2015 under the nursing facility moratorium exception process in section 144A.073. When each facility's moratorium exception construction project is completed, the facility must receive the rate adjustment allowed under subdivision 4f. In addition to that rate adjustment, facilities with at least 120 active beds, but not more than 149 active beds, as of January 1, 2015, must have their construction project rate adjustment increased by an additional $4; and facilities with at least 150 active beds, but not more than 160 active beds, as of January 1, 2015, must have their construction project rate adjustment increased by an additional $12.50.

(b) Notwithstanding any other law to the contrary, money available under section 144A.073, subdivision 11, after the completion of the moratorium exception approval process in 2015 under section 144A.073, subdivision 3, shall be used to reduce the fiscal impact to the medical assistance budget for the increases allowed in this subdivision.

Subd. 4j. **Construction project rate increase for certain nursing facilities.** (a) This subdivision applies to nursing facilities:

(1) located in Ramsey County;

(2) with at least 130 active beds as of September 30, 2017;

(3) with a portion of beds dually certified for Medicare and Medicaid and a portion of beds certified for Medicaid only; and

(4) with debt service payments that are not being covered by the existing property payment rate on September 30, 2017.

(b) The commissioner shall increase the property rate of each facility meeting the qualifications of this subdivision by $7.55.

(c) Notwithstanding any other law to the contrary, money available under section 144A.073, subdivision 15, after the completion of the 2018 moratorium exception approval process under section 144A.073, subdivision 3, shall be used to pay the medical assistance cost for the property rate increase in this subdivision.

256L.11 PROVIDER PAYMENT.

Subd. 6a. **Dental providers.** Effective for dental services provided to MinnesotaCare enrollees on or after January 1, 2018, the commissioner shall increase payment rates to dental providers by 54 percent. Payments made to prepaid health plans under section 256L.12 shall reflect the payment increase described in this subdivision. The prepaid health plans under contract with the commissioner shall provide payments to dental providers that are at least equal to a rate that includes the payment rate specified in this subdivision, and if applicable to the provider, the rates described under subdivision 7.

256R.36 HOLD HARMLESS.

No nursing facility's operating payment rate, plus its employer health insurance costs portion of the external fixed costs payment rate, will be less than its prior system operating cost payment rate.

256R.40 NURSING FACILITY VOLUNTARY CLOSURE; ALTERNATIVES.

Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Closure" means the cessation of operations of a nursing facility and delicensure and decertification of all beds within the facility.

(c) "Closure plan" means a plan to close a nursing facility and reallocate a portion of the resulting savings to provide planned closure rate adjustments at other facilities.

(d) "Commencement of closure" means the date on which residents and designated representatives are notified of a planned closure as provided in section 144A.161, subdivision 5a, as part of an approved closure plan.

(e) "Completion of closure" means the date on which the final resident of the nursing facility designated for closure in an approved closure plan is discharged from the facility or the date that beds from a partial closure are delicensed and decertified.

(f) "Partial closure" means the delicensure and decertification of a portion of the beds within the facility.

(g) "Planned closure rate adjustment" means an increase in a nursing facility's operating rates resulting from a planned closure or a planned partial closure of another facility.

Subd. 2. **Applications for planned closure rate.** (a) To be considered for approval of a planned closure, an application must include:

(1) a description of the proposed closure plan, which must include identification of the facility or facilities to receive a planned closure rate adjustment;

(2) the proposed timetable for any proposed closure, including the proposed dates for announcement to residents, commencement of closure, and completion of closure;

(3) if available, the proposed relocation plan for current residents of any facility designated for closure. If a relocation plan is not available, the application must include a statement agreeing to develop a relocation plan designed to comply with section 144A.161;

(4) a description of the relationship between the nursing facility that is proposed for closure and the nursing facility or facilities proposed to receive the planned closure rate adjustment. If these facilities are not under common ownership, copies of any contracts, purchase agreements, or other documents establishing a relationship or proposed relationship must be provided; and

(5) documentation, in a format approved by the commissioner, that all the nursing facilities receiving a planned closure rate adjustment under the plan have accepted joint and several liability for recovery of overpayments under section 256B.0641, subdivision 2, for the facilities designated for closure under the plan.

(b) The application must also address the criteria listed in subdivision 3.

Subd. 3. **Criteria for review of application.** In reviewing and approving closure proposals, the commissioner shall consider, but not be limited to, the following criteria:

(1) improved quality of care and quality of life for consumers;

(2) closure of a nursing facility that has a poor physical plant;

(3) the existence of excess nursing facility beds, measured in terms of beds per thousand persons aged 85 or older. The excess must be measured in reference to:

(i) the county in which the facility is located. A facility in a county that is in the lowest quartile of counties with reference to beds per thousand persons aged 85 or older is not in an area of excess capacity;

(ii) the county and all contiguous counties;

(iii) the region in which the facility is located; or

(iv) the facility's service area. The facility shall indicate in its application the service area it believes is appropriate for this measurement;

(4) low-occupancy rates, provided that the unoccupied beds are not the result of a personnel shortage. In analyzing occupancy rates, the commissioner shall examine waiting lists in the applicant facility and at facilities in the surrounding area, as determined under clause (3);

(5) evidence of coordination between the community planning process and the facility application. If the planning group does not support a level of nursing facility closures that the commissioner considers to be reasonable, the commissioner may approve a planned closure proposal without its support;

(6) proposed usage of funds available from a planned closure rate adjustment for care-related purposes;

(7) innovative use planned for the closed facility's physical plant;

(8) evidence that the proposal serves the interests of the state; and

(9) evidence of other factors that affect the viability of the facility, including excessive nursing pool costs.

Subd. 4. **Review and approval of applications.** (a) The commissioner, in consultation with the commissioner of health, shall approve or deny an application within 30 days after receiving it. The commissioner may appoint an advisory review panel composed of representatives of counties, consumers, and providers to review proposals and provide comments and recommendations to the committee. The commissioners of human services and health shall provide staff and technical assistance to the committee for the review and analysis of proposals.

(b) Approval of a planned closure expires 18 months after approval by the commissioner unless commencement of closure has begun.

(c) The commissioner may change any provision of the application to which the applicant, the regional planning group, and the commissioner agree.

Subd. 5. **Planned closure rate adjustment.** (a) The commissioner shall calculate the amount of the planned closure rate adjustment available under subdivision 6 according to clauses (1) to (4):

(1) the amount available is the net reduction of nursing facility beds multiplied by $2,080;

(2) the total number of beds in the nursing facility or facilities receiving the planned closure rate adjustment must be identified;

(3) capacity days are determined by multiplying the number determined under clause (2) by 365; and

(4) the planned closure rate adjustment is the amount available in clause (1), divided by capacity days determined under clause (3).

(b) A planned closure rate adjustment under this section is effective on the first day of the month of January or July, whichever occurs immediately following completion of closure of the facility designated for closure in the application and becomes part of the nursing facility's external fixed payment rate.

(c) Upon the request of a closing facility, the commissioner must allow the facility a closure rate adjustment as provided under section 144A.161, subdivision 10.

(d) A facility that has received a planned closure rate adjustment may reassign it to another facility that is under the same ownership at any time within three years of its effective date. The amount of the adjustment is computed according to paragraph (a).

(e) If the per bed dollar amount specified in paragraph (a), clause (1), is increased, the commissioner shall recalculate planned closure rate adjustments for facilities that delicense beds under this section on or after July 1, 2001, to reflect the increase in the per bed dollar amount. The recalculated planned closure rate adjustment is effective from the date the per bed dollar amount is increased.

Subd. 6. **Assignment of closure rate to another facility.** A facility or facilities reimbursed under this chapter with a closure plan approved by the commissioner under subdivision 4 may assign a planned closure rate adjustment to another facility or facilities that are not closing or in the case of a partial closure, to the facility undertaking the partial closure. A facility may also elect to have a planned closure rate adjustment shared equally by the five nursing facilities with the lowest total operating payment rates in the state development region designated under section 462.385, in which the facility that is closing is located. The planned closure rate adjustment must be calculated under subdivision 5. Facilities that delicense beds without a closure plan, or whose closure plan is not approved by the commissioner, are not eligible to assign a planned closure rate adjustment under subdivision 5, unless they: (1) are delicensing five or fewer beds, or less than six percent of their total licensed bed capacity, whichever is greater; (2) are located in a county in the top three quartiles of beds per 1,000 persons aged 65 or older; and (3) have not delicensed beds in the prior three months. Facilities meeting these criteria are eligible to assign the amount calculated under subdivision 5 to themselves. If a facility is delicensing the greater of six or more beds, or six percent or more of its total licensed bed capacity, and does not have an approved closure plan or is not eligible for the adjustment under subdivision 5, the commissioner shall calculate the amount the facility would have been eligible to assign under subdivision 5, and shall use this amount to

provide equal rate adjustments to the five nursing facilities with the lowest total operating payment rates in the state development region designated under section 462.385, in which the facility that delicensed beds is located.

Subd. 7. **Other rate adjustments.** Facilities receiving planned closure rate adjustments remain eligible for any applicable rate adjustments provided under this chapter.

256R.41 SINGLE-BED ROOM INCENTIVE.

(a) Beginning July 1, 2005, the operating payment rate for nursing facilities reimbursed under this chapter shall be increased by 20 percent multiplied by the ratio of the number of new single-bed rooms created divided by the number of active beds on July 1, 2005, for each bed closure that results in the creation of a single-bed room after July 1, 2005. The commissioner may implement rate adjustments for up to 3,000 new single-bed rooms each year. For eligible bed closures for which the commissioner receives a notice from a facility that a bed has been delicensed and a new single-bed room has been established, the rate adjustment in this paragraph shall be effective on either the first day of the month of January or July, whichever occurs first following the date of the bed delicensure.

(b) A nursing facility is prohibited from discharging residents for purposes of establishing single-bed rooms. A nursing facility must submit documentation to the commissioner in a form prescribed by the commissioner, certifying the occupancy status of beds closed to create single-bed rooms. In the event that the commissioner determines that a facility has discharged a resident for purposes of establishing a single-bed room, the commissioner shall not provide a rate adjustment under paragraph (a).

Laws 2010, First Special Session chapter 1, article 25, section 3, subdivision 10

Sec. 3. **COMMISSIONER OF HUMAN SERVICES**

Subd. 10. **State-Operated Services**

Obsolete Laundry Depreciation Account. $669,000, or the balance, whichever is greater, must be transferred from the state-operated services laundry depreciation account in the special revenue fund and deposited into the general fund by June 30, 2010. This paragraph is effective the day following final enactment.

Operating Budget Reductions. No operating budget reductions enacted in Laws 2010, chapter 200, or in this act shall be allocated to state-operated services.

Prohibition on Transferring Funds. The commissioner shall not transfer mental health grants to state-operated services without specific legislative approval. Notwithstanding any contrary provision in this article, this paragraph shall not expire.

(a) **Adult Mental Health Services**	-0-	6,888,000

Base Adjustment. The general fund base is decreased by $12,286,000 in fiscal year 2012 and $12,394,000 in fiscal year 2013.

Appropriation Requirements. (a) The general fund appropriation to the commissioner includes funding for the following:

(1) to a community collaborative to begin providing crisis center services in the Mankato area that are comparable to the crisis services provided prior to the closure of the Mankato Crisis Center. The commissioner shall recruit former employees of the Mankato Crisis Center who were recently laid off to staff the new crisis services. The commissioner shall obtain legislative approval prior to discontinuing this funding;

(2) to maintain the building in Eveleth that currently houses community transition services and to establish a psychiatric intensive therapeutic foster home as an enterprise activity. The commissioner shall request a waiver amendment to allow CADI funding for psychiatric intensive therapeutic foster care services provided in the same location and building as the community transition services. If the federal government does not approve the waiver amendment, the commissioner shall continue to pay the lease for the building out of the state-operated services budget until the commissioner of administration subleases the space or until the lease expires, and shall establish the psychiatric intensive therapeutic foster home at a different site. The commissioner shall make diligent efforts to sublease the space;

(3) to convert the community behavioral health hospitals in Wadena and Willmar to facilities that

provide more suitable services based on the needs of the community, which may include, but are not limited to, psychiatric extensive recovery treatment services. The commissioner may also establish other community-based services in the Willmar and Wadena areas that deliver the appropriate level of care in response to the express needs of the communities. The services established under this provision must be staffed by state employees.

(4) to continue the operation of the dental clinics in Brainerd, Cambridge, Faribault, Fergus Falls, and Willmar at the same level of care and staffing that was in effect on March 1, 2010. The commissioner shall not proceed with the planned closure of the dental clinics, and shall not discontinue services or downsize any of the state-operated dental clinics without specific legislative approval. The commissioner shall continue to bill for services provided to obtain medical assistance critical access dental payments and cost-based payment rates as provided in Minnesota Statutes, section 256B.76, subdivision 2, and shall bill for services provided three months retroactively from the date of this act. This appropriation is onetime;

(5) to convert the Minnesota Neurorehabilitation Hospital in Brainerd to a neurocognitive psychiatric extensive recovery treatment service; and

(6) to convert the Minnesota extended treatment options (METO) program to the following community-based services provided by state employees: (i) psychiatric extensive recovery treatment services; (ii) intensive transitional foster homes as enterprise activities; and (iii) other community-based support services. The provisions under Minnesota Statutes, section 252.025, subdivision 7, are applicable to the METO services established under this clause. Notwithstanding Minnesota Statutes, section 246.18, subdivision 8, any revenue lost to the general fund by the conversion of METO to new services must be replaced by revenue from the new services to offset the lost revenue to the general fund until June 30, 2013. Any revenue generated in excess of this amount shall be deposited into the special revenue fund under Minnesota Statutes, section 246.18, subdivision 8.

(b) The commissioner shall not move beds from the Anoka-Metro Regional Treatment Center to the psychiatric nursing facility at St. Peter without specific legislative approval.

(c) The commissioner shall implement changes, including the following, to save a minimum of $6,006,000 beginning in fiscal year 2011, and report to the legislature the specific initiatives implemented and the savings allocated to each one, including:

(1) maximizing budget savings through strategic employee staffing; and

(2) identifying and implementing cost reductions in cooperation with state-operated services employees.

Base level funding is reduced by $6,006,000 effective fiscal year 2011.

(d) The commissioner shall seek certification or approval from the federal government for the new services under paragraph (a) that are eligible for federal financial participation and deposit the revenue associated with these new services in the account established under Minnesota Statutes, section 246.18, subdivision 8, unless otherwise specified.

(e) Notwithstanding any contrary provision in this article, this rider shall not expire.

(b) **Minnesota Sex Offender Services**	-0-	(145,000)

Sex Offender Services. Base level funding for Minnesota sex offender services is reduced by $418,000 in fiscal year 2012 and $419,000 in fiscal year 2013 for the 50-bed sex offender treatment program within the Moose Lake correctional facility in which Department of Human Services staff from Minnesota sex offender services provide clinical treatment to incarcerated offenders. This reduction shall become part of the base for the Department of Human Services.

Interagency Agreements. The commissioner of human services may enter into interagency agreements with the commissioner of corrections to continue sex offender treatment and chemical dependency treatment on a cost-sharing basis, in which each department pays 50 percent of the costs of these services.

Base Adjustment. The general fund base is increased by $418,000 in fiscal year 2012 and $419,000 in fiscal year 2013.

2960.3030 CAPACITY LIMITS.

Subp. 3. **Exceptions to capacity limits.** A variance may be granted to allow up to eight foster children in addition to the license holder's own children if the conditions in items A to E are met:

A. placement is necessary to keep a sibling group together, to keep a child in the child's home community, or is necessary because the foster child was formerly living in the home and it would be in the child's best interest to be placed there again;

B. there is no risk of harm to the children currently in the home;

C. the structural characteristics of the home, including sleeping space, can accommodate the additional foster children;

D. the home remains in compliance with applicable zoning, health, fire, and building codes; and

E. the statement of intended use states the conditions for the exception to capacity limits and explains how the license holder will maintain a ratio of adults to children which ensures the safety and appropriate supervision of all the children in the foster home.

A foster home licensed by the Department of Corrections need not meet the requirement in item A.

3400.0185 TERMINATION AND ADVERSE ACTIONS; NOTICE REQUIRED.

Subp. 5. **Notice to providers of actions adverse to the provider.** The county must give a provider written notice of the following actions adverse to the provider: a denial of authorization, a termination of authorization, a reduction in the number of hours of care with that provider, and a determination that the provider has an overpayment. The notice must include the following information:

A. a description of the adverse action;

B. the effective date of the adverse action; and

C. a statement that unless a family appeals the adverse action before the effective date or the provider appeals the overpayment determination, the adverse action will occur on the effective date. The notice must be mailed to the provider at least 15 calendar days before the effective date of the adverse action.

6400.6970 FEES.

Subpart 1. **Payment types and nonrefundability.** The fees imposed in this part shall be paid by cash, personal check, bank draft, cashier's check, or money order made payable to the Board of Examiners for Nursing Home Administrators. All fees are nonrefundable.

Subp. 2. **Amounts.** The amount of fees may be set by the board with the approval of the Department of Management and Budget up to the limits provided in this part depending upon the total amount required to sustain board operations under Minnesota Statutes, section 16A.1285, subdivision 2. Information about fees in effect at any time is available from the board office. The maximum amounts of fees are:

A. application for licensure, $150;

B. for a prospective applicant for a review of education and experience advisory to the license application, $50, to be applied to the fee for application for licensure if the latter is submitted within one year of the request for review of education and experience;

C. state examination, $75;

D. initial license, $200 if issued between July 1 and December 31, $100 if issued between January 1 and June 30;

E. acting administrator permit, $250;

F. renewal license, $200;

G. duplicate license, $10;

H. fee to a sponsor for review of individual continuing education seminars, institutes, workshops, or home study courses:

(1) for less than seven clock hours, $30; and

(2) for seven or more clock hours, $50;

I. fee to a licensee for review of continuing education seminars, institutes, workshops, or home study courses not previously approved for a sponsor and submitted with an application for license renewal:

(1) for less than seven clock hours total, $30; and

(2) for seven or more clock hours total, $50;

J. late renewal fee, $50;

K. fee to a licensee for verification of licensure status and examination scores, $30; and

L. registration as a registered continuing education sponsor, $1,000.

7200.6100 FEES.

The nonrefundable fees for licensure payable to the board are as follows:

A. application for admission to national standardized examination, $150;

B. application for professional responsibility examination, $150;

C. application for licensure as a licensed psychologist, $500;

D. renewal of license for a licensed psychologist, $500;

E. late renewal of license for a licensed psychologist, $250;

F. application for converting from master's to doctoral level licensure, $150; and

G. application for guest licensure, $150.

7200.6105 CONTINUING EDUCATION SPONSOR FEE.

A sponsor applying for approval of a continuing education activity pursuant to part 7200.3830, subpart 2, shall submit with the application a fee of $80 for each activity.

9502.0425 PHYSICAL ENVIRONMENT.

Subp. 4. **Means of escape.** From each room of the residence used by children, there must be two means of escape. One means of escape must be a stairway or door leading to the floor of exit discharge. The other must be a door or window leading directly outside. The window must be openable without special knowledge. It must have a clear opening of not less than 5.7 square feet and have a minimum clear opening dimension of 20 inches wide and 24 inches high. The window must be within 48 inches from the floor.

Subp. 16. **Extinguishers.** A portable, operational, multipurpose, dry chemical fire extinguisher with a minimum 2 A 10 BC rating must be maintained in the kitchen and cooking areas of the residence at all times. All caregivers shall know how to use the fire extinguisher.

Subp. 17. **Smoke detection systems.** Smoke detectors that have been listed by the Underwriter Laboratory must be properly installed and maintained on all levels.

9503.0155 FACILITY.

Subp. 8. **Telephone; posted numbers.** A telephone that is not coin operated must be located within the center. A list of emergency numbers must be posted next to the telephone. If a 911 emergency number is not available, the numbers listed must be those of the local fire department, police department, emergency transportation, and poison control center.

9505.0370 DEFINITIONS.

Subpart 1. **Scope.** For parts 9505.0370 to 9505.0372, the following terms have the meanings given them.

Subp. 2. **Adult day treatment.** "Adult day treatment" or "adult day treatment program" means a structured program of treatment and care.

Subp. 3. **Child.** "Child" means a person under 18 years of age.

Subp. 4. **Client.** "Client" means an eligible recipient who is determined to have or who is being assessed for a mental illness as specified in part 9505.0371.

Subp. 5. **Clinical summary.** "Clinical summary" means a written description of a clinician's formulation of the cause of the client's mental health symptoms, the client's prognosis, and the likely consequences of the symptoms; how the client meets the criteria for the diagnosis by describing the client's symptoms, the duration of symptoms, and functional impairment; an analysis of the client's other symptoms, strengths, relationships, life situations, cultural influences, and health concerns and their potential interaction with the diagnosis and formulation of the client's mental health condition; and alternative diagnoses that were considered and ruled out.

Subp. 6. **Clinical supervision.** "Clinical supervision" means the documented time a clinical supervisor and supervisee spend together to discuss the supervisee's work, to review individual client cases, and for the supervisee's professional development. It includes the documented oversight and supervision responsibility for planning, implementation, and evaluation of services for a client's mental health treatment.

Subp. 7. **Clinical supervisor.** "Clinical supervisor" means the mental health professional who is responsible for clinical supervision.

Subp. 8. **Cultural competence or culturally competent.** "Cultural competence" or "culturally competent" means the mental health provider's:

A. awareness of the provider's own cultural background, and the related assumptions, values, biases, and preferences that influence assessment and intervention processes;

B. ability and will to respond to the unique needs of an individual client that arise from the client's culture;

C. ability to utilize the client's culture as a resource and as a means to optimize mental health care; and

D. willingness to seek educational, consultative, and learning experiences to expand knowledge of and increase effectiveness with culturally diverse populations.

Subp. 9. **Cultural influences.** "Cultural influences" means historical, geographical, and familial factors that affect assessment and intervention processes. Cultural influences that are relevant to the client may include the client's:

A. racial or ethnic self-identification;

B. experience of cultural bias as a stressor;

C. immigration history and status;

D. level of acculturation;

E. time orientation;

F. social orientation;

G. verbal communication style;

H. locus of control;

I. spiritual beliefs; and

J. health beliefs and the endorsement of or engagement in culturally specific healing practices.

Subp. 10. **Culture.** "Culture" means the distinct ways of living and understanding the world that are used by a group of people and are transmitted from one generation to another or adopted by an individual.

Subp. 11. **Diagnostic assessment.** "Diagnostic assessment" means a written assessment that documents a clinical and functional face-to-face evaluation of the client's mental health, including the nature, severity and impact of behavioral difficulties, functional impairment, and subjective distress of the client, and identifies the client's strengths and resources.

Subp. 12. **Dialectical behavior therapy.** "Dialectical behavior therapy" means an evidence-based treatment approach provided in an intensive outpatient treatment program using a combination of individualized rehabilitative and psychotherapeutic interventions. A dialectical behavior therapy program is certified by the commissioner and involves the following service components: individual dialectical behavior therapy, group skills training, telephone coaching, and team consultation meetings.

Subp. 13. **Explanation of findings.** "Explanation of findings" means the explanation of a client's diagnostic assessment, psychological testing, treatment program, and consultation with culturally informed mental health consultants as required under parts 9520.0900 to 9520.0926, or other accumulated data and recommendations to the client, client's family, primary caregiver, or other responsible persons.

Subp. 14. **Family.** "Family" means a person who is identified by the client or the client's parent or guardian as being important to the client's mental health treatment. Family may include, but is not limited to, parents, children, spouse, committed partners, former spouses, persons related by blood or adoption, or persons who are presently residing together as a family unit.

Subp. 15. **Individual treatment plan.** "Individual treatment plan" means a written plan that outlines and defines the course of treatment. It delineates the goals, measurable objectives, target dates for achieving specific goals, main participants in treatment process, and recommended services that are based on the client's diagnostic assessment and other meaningful data that are needed to aid the client's recovery and enhance resiliency.

Subp. 16. **Medication management.** "Medication management" means a service that determines the need for or effectiveness of the medication prescribed for the treatment of a client's symptoms of a mental illness.

Subp. 17. **Mental health practitioner.** "Mental health practitioner" means a person who is qualified according to part 9505.0371, subpart 5, items B and C, and provides mental health services to a client with a mental illness under the clinical supervision of a mental health professional.

Subp. 18. **Mental health professional.** "Mental health professional" means a person who is enrolled to provide medical assistance services and is qualified according to part 9505.0371, subpart 5, item A.

Subp. 19. **Mental health telemedicine.** "Mental health telemedicine" has the meaning given in Minnesota Statutes, section 256B.0625, subdivision 46.

Subp. 20. **Mental illness.** "Mental illness" has the meaning given in Minnesota Statutes, section 245.462, subdivision 20. "Mental illness" includes "emotional disturbance" as defined in Minnesota Statutes, section 245.4871, subdivision 15.

Subp. 21. **Multidisciplinary staff.** "Multidisciplinary staff" means a group of individuals from diverse disciplines who come together to provide services to clients under part 9505.0372, subparts 8, 9, and 10.

Subp. 22. **Neuropsychological assessment.** "Neuropsychological assessment" means a specialized clinical assessment of the client's underlying cognitive abilities related to thinking, reasoning, and judgment that is conducted by a qualified neuropsychologist.

Subp. 23. **Neuropsychological testing.** "Neuropsychological testing" means administering standardized tests and measures designed to evaluate the client's ability to attend to, process, interpret, comprehend, communicate, learn and recall information; and use problem-solving and judgment.

Subp. 24. **Partial hospitalization program.** "Partial hospitalization program" means a provider's time-limited, structured program of psychotherapy and other therapeutic services, as defined in United States Code, title 42, chapter 7, subchapter XVIII, part E, section 1395x, (ff), that is provided in an outpatient hospital facility or community mental health center that meets Medicare requirements to provide partial hospitalization services.

Subp. 25. **Primary caregiver.** "Primary caregiver" means a person, other than the facility staff, who has primary legal responsibility for providing the client with food, clothing, shelter, direction, guidance, and nurturance.

Subp. 26. **Psychological testing.** "Psychological testing" means the use of tests or other psychometric instruments to determine the status of the recipient's mental, intellectual, and emotional functioning.

Subp. 27. **Psychotherapy.** "Psychotherapy" means treatment of a client with mental illness that applies the most appropriate psychological, psychiatric, psychosocial, or interpersonal method that conforms to prevailing community standards of professional practice to meet the mental health needs of the client.

Subp. 28. **Supervisee.** "Supervisee" means an individual who requires clinical supervision because the individual does not meet mental health professional standards in part 9505.0371, subpart 5, item A.

9505.0371 MEDICAL ASSISTANCE COVERAGE REQUIREMENTS FOR OUTPATIENT MENTAL HEALTH SERVICES.

Subpart 1. **Purpose.** This part describes the requirements that outpatient mental health services must meet to receive medical assistance reimbursement.

Subp. 2. **Client eligibility for mental health services.** The following requirements apply to mental health services:

A. The provider must use a diagnostic assessment as specified in part 9505.0372 to determine a client's eligibility for mental health services under this part, except:

(1) prior to completion of a client's initial diagnostic assessment, a client is eligible for:

(a) one explanation of findings;

(b) one psychological testing; and

(c) either one individual psychotherapy session, one family psychotherapy session, or one group psychotherapy session; and

(2) for a client who is not currently receiving mental health services covered by medical assistance, a crisis assessment as specified in Minnesota Statutes, section

256B.0624 or 256B.0944, conducted in the past 60 days may be used to allow up to ten sessions of mental health services within a 12-month period.

B. A brief diagnostic assessment must meet the requirements of part 9505.0372, subpart 1, item D, and:

(1) may be used to allow up to ten sessions of mental health services as specified in part 9505.0372 within a 12-month period before a standard or extended diagnostic assessment is required when the client is:

(a) a new client; or

(b) an existing client who has had fewer than ten sessions of psychotherapy in the previous 12 months and is projected to need fewer than ten sessions of psychotherapy in the next 12 months, or who only needs medication management; and

(2) may be used for a subsequent annual assessment, if based upon the client's treatment history and the provider's clinical judgment, the client will need ten or fewer sessions of mental health services in the upcoming 12-month period; and

(3) must not be used for:

(a) a client or client's family who requires a language interpreter to participate in the assessment unless the client meets the requirements of subitem (1), unit (b), or (2); or

(b) more than ten sessions of mental health services in a 12-month period. If, after completion of ten sessions of mental health services, the mental health professional determines the need for additional sessions, a standard assessment or extended assessment must be completed.

C. For a child, a new standard or extended diagnostic assessment must be completed:

(1) when the child does not meet the criteria for a brief diagnostic assessment;

(2) at least annually following the initial diagnostic assessment, if:

(a) additional services are needed; and

(b) the child does not meet criteria for brief assessment;

(3) when the child's mental health condition has changed markedly since the child's most recent diagnostic assessment; or

(4) when the child's current mental health condition does not meet criteria of the child's current diagnosis.

D. For an adult, a new standard diagnostic assessment or extended diagnostic assessment must be completed:

(1) when the adult does not meet the criteria for a brief diagnostic assessment or an adult diagnostic assessment update;

(2) at least every three years following the initial diagnostic assessment for an adult who receives mental health services;

(3) when the adult's mental health condition has changed markedly since the adult's most recent diagnostic assessment; or

(4) when the adult's current mental health condition does not meet criteria of the current diagnosis.

E. An adult diagnostic assessment update must be completed at least annually unless a new standard or extended diagnostic assessment is performed. An adult diagnostic assessment update must include an update of the most recent standard or extended diagnostic

assessment and any recent adult diagnostic assessment updates that have occurred since the last standard or extended diagnostic assessment.

Subp. 3. **Authorization for mental health services.** Mental health services under this part are subject to authorization criteria and standards published by the commissioner according to Minnesota Statutes, section 256B.0625, subdivision 25.

Subp. 4. **Clinical supervision.**

A. Clinical supervision must be based on each supervisee's written supervision plan and must:

(1) promote professional knowledge, skills, and values development;

(2) model ethical standards of practice;

(3) promote cultural competency by:

(a) developing the supervisee's knowledge of cultural norms of behavior for individual clients and generally for the clients served by the supervisee regarding the client's cultural influences, age, class, gender, sexual orientation, literacy, and mental or physical disability;

(b) addressing how the supervisor's and supervisee's own cultures and privileges affect service delivery;

(c) developing the supervisee's ability to assess their own cultural competence and to identify when consultation or referral of the client to another provider is needed; and

(d) emphasizing the supervisee's commitment to maintaining cultural competence as an ongoing process;

(4) recognize that the client's family has knowledge about the client and will continue to play a role in the client's life and encourage participation among the client, client's family, and providers as treatment is planned and implemented; and

(5) monitor, evaluate, and document the supervisee's performance of assessment, treatment planning, and service delivery.

B. Clinical supervision must be conducted by a qualified supervisor using individual or group supervision. Individual or group face-to-face supervision may be conducted via electronic communications that utilize interactive telecommunications equipment that includes at a minimum audio and video equipment for two-way, real-time, interactive communication between the supervisor and supervisee, and meet the equipment and connection standards of part 9505.0370, subpart 19.

(1) Individual supervision means one or more designated clinical supervisors and one supervisee.

(2) Group supervision means one clinical supervisor and two to six supervisees in face-to-face supervision.

C. The supervision plan must be developed by the supervisor and the supervisee. The plan must be reviewed and updated at least annually. For new staff the plan must be completed and implemented within 30 days of the new staff person's employment. The supervision plan must include:

(1) the name and qualifications of the supervisee and the name of the agency in which the supervisee is being supervised;

(2) the name, licensure, and qualifications of the supervisor;

(3) the number of hours of individual and group supervision to be completed by the supervisee including whether supervision will be in person or by some other method approved by the commissioner;

(4) the policy and method that the supervisee must use to contact the clinical supervisor during service provision to a supervisee;

(5) procedures that the supervisee must use to respond to client emergencies; and

(6) authorized scope of practices, including:

(a) description of the supervisee's service responsibilities;

(b) description of client population; and

(c) treatment methods and modalities.

D. Clinical supervision must be recorded in the supervisee's supervision record. The documentation must include:

(1) date and duration of supervision;

(2) identification of supervision type as individual or group supervision;

(3) name of the clinical supervisor;

(4) subsequent actions that the supervisee must take; and

(5) date and signature of the clinical supervisor.

E. Clinical supervision pertinent to client treatment changes must be recorded by a case notation in the client record after supervision occurs.

Subp. 5. **Qualified providers.** Medical assistance covers mental health services according to part 9505.0372 when the services are provided by mental health professionals or mental health practitioners qualified under this subpart.

A. A mental health professional must be qualified in one of the following ways:

(1) in clinical social work, a person must be licensed as an independent clinical social worker by the Minnesota Board of Social Work under Minnesota Statutes, chapter 148D until August 1, 2011, and thereafter under Minnesota Statutes, chapter 148E;

(2) in psychology, a person licensed by the Minnesota Board of Psychology under Minnesota Statutes, sections 148.88 to 148.98, who has stated to the board competencies in the diagnosis and treatment of mental illness;

(3) in psychiatry, a physician licensed under Minnesota Statutes, chapter 147, who is certified by the American Board of Psychiatry and Neurology or is eligible for board certification;

(4) in marriage and family therapy, a person licensed as a marriage and family therapist by the Minnesota Board of Marriage and Family Therapy under Minnesota Statutes, sections 148B.29 to 148B.39, and defined in parts 5300.0100 to 5300.0350;

(5) in professional counseling, a person licensed as a professional clinical counselor by the Minnesota Board of Behavioral Health and Therapy under Minnesota Statutes, section 148B.5301;

(6) a tribally approved mental health care professional, who meets the standards in Minnesota Statutes, section 256B.02, subdivision 7, paragraphs (b) and (c), and who is serving a federally recognized Indian tribe; or

(7) in psychiatric nursing, a registered nurse who is licensed under Minnesota Statutes, sections 148.171 to 148.285, and meets one of the following criteria:

(a) is certified as a clinical nurse specialist;

(b) for children, is certified as a nurse practitioner in child or adolescent or family psychiatric and mental health nursing by a national nurse certification organization; or

(c) for adults, is certified as a nurse practitioner in adult or family psychiatric and mental health nursing by a national nurse certification organization.

B. A mental health practitioner for a child client must have training working with children. A mental health practitioner for an adult client must have training working with adults. A mental health practitioner must be qualified in at least one of the following ways:

(1) holds a bachelor's degree in one of the behavioral sciences or related fields from an accredited college or university; and

(a) has at least 2,000 hours of supervised experience in the delivery of mental health services to clients with mental illness; or

(b) is fluent in the non-English language of the cultural group to which at least 50 percent of the practitioner's clients belong, completes 40 hours of training in the delivery of services to clients with mental illness, and receives clinical supervision from a mental health professional at least once a week until the requirements of 2,000 hours of supervised experience are met;

(2) has at least 6,000 hours of supervised experience in the delivery of mental health services to clients with mental illness. Hours worked as a mental health behavioral aide I or II under Minnesota Statutes, section 256B.0943, subdivision 7, may be included in the 6,000 hours of experience for child clients;

(3) is a graduate student in one of the mental health professional disciplines defined in item A and is formally assigned by an accredited college or university to an agency or facility for clinical training;

(4) holds a master's or other graduate degree in one of the mental health professional disciplines defined in item A from an accredited college or university; or

(5) is an individual who meets the standards in Minnesota Statutes, section 256B.02, subdivision 7, paragraphs (b) and (c), who is serving a federally recognized Indian tribe.

C. Medical assistance covers diagnostic assessment, explanation of findings, and psychotherapy performed by a mental health practitioner working as a clinical trainee when:

(1) the mental health practitioner is:

(a) complying with requirements for licensure or board certification as a mental health professional, as defined in item A, including supervised practice in the delivery of mental health services for the treatment of mental illness; or

(b) a student in a bona fide field placement or internship under a program leading to completion of the requirements for licensure as a mental health professional defined in item A; and

(2) the mental health practitioner's clinical supervision experience is helping the practitioner gain knowledge and skills necessary to practice effectively and independently. This may include supervision of:

(a) direct practice;

(b) treatment team collaboration;

(c) continued professional learning; and

(d) job management.

D. A clinical supervisor must:

(1) be a mental health professional licensed as specified in item A;

(2) hold a license without restrictions that has been in good standing for at least one year while having performed at least 1,000 hours of clinical practice;

(3) be approved, certified, or in some other manner recognized as a qualified clinical supervisor by the person's professional licensing board, when this is a board requirement;

(4) be competent as demonstrated by experience and graduate-level training in the area of practice and the activities being supervised;

(5) not be the supervisee's blood or legal relative or cohabitant, or someone who has acted as the supervisee's therapist within the past two years;

(6) have experience and skills that are informed by advanced training, years of experience, and mastery of a range of competencies that demonstrate the following:

(a) capacity to provide services that incorporate best practice;

(b) ability to recognize and evaluate competencies in supervisees;

(c) ability to review assessments and treatment plans for accuracy and appropriateness;

(d) ability to give clear direction to mental health staff related to alternative strategies when a client is struggling with moving towards recovery; and

(e) ability to coach, teach, and practice skills with supervisees;

(7) accept full professional liability for a supervisee's direction of a client's mental health services;

(8) instruct a supervisee in the supervisee's work, and oversee the quality and outcome of the supervisee's work with clients;

(9) review, approve, and sign the diagnostic assessment, individual treatment plans, and treatment plan reviews of clients treated by a supervisee;

(10) review and approve the progress notes of clients treated by the supervisee according to the supervisee's supervision plan;

(11) apply evidence-based practices and research-informed models to treat clients;

(12) be employed by or under contract with the same agency as the supervisee;

(13) develop a clinical supervision plan for each supervisee;

(14) ensure that each supervisee receives the guidance and support needed to provide treatment services in areas where the supervisee practices;

(15) establish an evaluation process that identifies the performance and competence of each supervisee; and

(16) document clinical supervision of each supervisee and securely maintain the documentation record.

Subp. 6. **Release of information.** Providers who receive a request for client information and providers who request client information must:

A. comply with data practices and medical records standards in Minnesota Statutes, chapter 13, and Code of Federal Regulations, title 45, part 164; and

B. subject to the limitations in item A, promptly provide client information, including a written diagnostic assessment, to other providers who are treating the client to ensure that the client will get services without undue delay.

Subp. 7. **Individual treatment plan.** Except as provided in subpart 2, item A, subitem (1), a medical assistance payment is available only for services provided in accordance with the client's written individual treatment plan (ITP). The client must be involved in the development, review, and revision of the client's ITP. For all mental health services, except

as provided in subpart 2, item A, subitem (1), and medication management, the ITP and subsequent revisions of the ITP must be signed by the client before treatment begins. The mental health professional or practitioner shall request the client, or other person authorized by statute to consent to mental health services for the client, to sign the client's ITP or revision of the ITP. In the case of a child, the child's parent, primary caregiver, or other person authorized by statute to consent to mental health services for the child shall be asked to sign the child's ITP and revisions of the ITP. If the client or authorized person refuses to sign the plan or a revision of the plan, the mental health professional or mental health practitioner shall note on the plan the refusal to sign the plan and the reason or reasons for the refusal. A client's individual treatment plan must be:

A. based on the client's current diagnostic assessment;

B. developed by identifying the client's service needs and considering relevant cultural influences to identify planned interventions that contain specific treatment goals and measurable objectives for the client; and

C. reviewed at least once every 90 days, and revised as necessary. Revisions to the initial individual treatment plan do not require a new diagnostic assessment unless the client's mental health status has changed markedly as provided in subpart 2.

Subp. 8. **Documentation.** To obtain medical assistance payment for an outpatient mental health service, a mental health professional or a mental health practitioner must promptly document:

A. in the client's mental health record:

(1) each occurrence of service to the client including the date, type of service, start and stop time, scope of the mental health service, name and title of the person who gave the service, and date of documentation; and

(2) all diagnostic assessments and other assessments, psychological test results, treatment plans, and treatment plan reviews;

B. the provider's contact with persons interested in the client such as representatives of the courts, corrections systems, or schools, or the client's other mental health providers, case manager, family, primary caregiver, legal representative, including the name and date of the contact or, if applicable, the reason the client's family, primary caregiver, or legal representative was not contacted; and

C. dates that treatment begins and ends and reason for the discontinuation of the mental health service.

Subp. 9. **Service coordination.** The provider must coordinate client services as authorized by the client as follows:

A. When a recipient receives mental health services from more than one mental health provider, each provider must coordinate mental health services they provide to the client with other mental health service providers to ensure services are provided in the most efficient manner to achieve maximum benefit for the client.

B. The mental health provider must coordinate mental health care with the client's physical health provider.

Subp. 10. **Telemedicine services.** Mental health services in part 9505.0372 covered as direct face-to-face services may be provided via two-way interactive video if it is medically appropriate to the client's condition and needs. The interactive video equipment and connection must comply with Medicare standards that are in effect at the time of service. The commissioner may specify parameters within which mental health services can be provided via telemedicine.

9505.0372 COVERED SERVICES.

Subpart 1. **Diagnostic assessment.** Medical assistance covers four types of diagnostic assessments when they are provided in accordance with the requirements in this subpart.

A. To be eligible for medical assistance payment, a diagnostic assessment must:

(1) identify a mental health diagnosis and recommended mental health services, which are the factual basis to develop the recipient's mental health services and treatment plan; or

(2) include a finding that the client does not meet the criteria for a mental health disorder.

B. A standard diagnostic assessment must include a face-to-face interview with the client and contain a written evaluation of a client by a mental health professional or practitioner working under clinical supervision as a clinical trainee according to part 9505.0371, subpart 5, item C. The standard diagnostic assessment must be done within the cultural context of the client and must include relevant information about:

(1) the client's current life situation, including the client's:

(a) age;

(b) current living situation, including household membership and housing status;

(c) basic needs status including economic status;

(d) education level and employment status;

(e) significant personal relationships, including the client's evaluation of relationship quality;

(f) strengths and resources, including the extent and quality of social networks;

(g) belief systems;

(h) contextual nonpersonal factors contributing to the client's presenting concerns;

(i) general physical health and relationship to client's culture; and

(j) current medications;

(2) the reason for the assessment, including the client's:

(a) perceptions of the client's condition;

(b) description of symptoms, including reason for referral;

(c) history of mental health treatment, including review of the client's records;

(d) important developmental incidents;

(e) maltreatment, trauma, or abuse issues;

(f) history of alcohol and drug usage and treatment;

(g) health history and family health history, including physical, chemical, and mental health history; and

(h) cultural influences and their impact on the client;

(3) the client's mental status examination;

(4) the assessment of client's needs based on the client's baseline measurements, symptoms, behavior, skills, abilities, resources, vulnerabilities, and safety needs;

(5) the screenings used to determine the client's substance use, abuse, or dependency and other standardized screening instruments determined by the commissioner;

(6) assessment methods and use of standardized assessment tools by the provider as determined and periodically updated by the commissioner;

(7) the client's clinical summary, recommendations, and prioritization of needed mental health, ancillary or other services, client and family participation in assessment and service preferences, and referrals to services required by statute or rule; and

(8) the client data that is adequate to support the findings on all axes of the current edition of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association; and any differential diagnosis.

C. An extended diagnostic assessment must include a face-to-face interview with the client and contain a written evaluation of a client by a mental health professional or practitioner working under clinical supervision as a clinical trainee according to part 9505.0371, subpart 5, item C. The face-to-face interview is conducted over three or more assessment appointments because the client's complex needs necessitate significant additional assessment time. Complex needs are those caused by acuity of psychotic disorder; cognitive or neurocognitive impairment; need to consider past diagnoses and determine their current applicability; co-occurring substance abuse use disorder; or disruptive or changing environments, communication barriers, or cultural considerations as documented in the assessment. For child clients, the appointments may be conducted outside the diagnostician's office for face-to-face consultation and information gathering with family members, doctors, caregivers, teachers, and other providers, with or without the child present, and may involve directly observing the child in various settings that the child frequents such as home, school, or care settings. To complete the diagnostic assessment with adult clients, the appointments may be conducted outside of the diagnostician's office for face-to-face assessment with the adult client. The appointment may involve directly observing the adult client in various settings that the adult frequents, such as home, school, job, service settings, or community settings. The appointments may include face-to-face meetings with the adult client and the client's family members, doctors, caregivers, teachers, social support network members, recovery support resource representatives, and other providers for consultation and information gathering for the diagnostic assessment. The components of an extended diagnostic assessment include the following relevant information:

(1) for children under age 5:

(a) utilization of the DC:0-3R diagnostic system for young children;

(b) an early childhood mental status exam that assesses the client's developmental, social, and emotional functioning and style both within the family and with the examiner and includes:

i. physical appearance including dysmorphic features;

ii. reaction to new setting and people and adaptation during evaluation;

iii. self-regulation, including sensory regulation, unusual behaviors, activity level, attention span, and frustration tolerance;

iv. physical aspects, including motor function, muscle tone, coordination, tics, abnormal movements, and seizure activity;

v. vocalization and speech production, including expressive and receptive language;

vi. thought, including fears, nightmares, dissociative states, and hallucinations;

vii. affect and mood, including modes of expression, range, responsiveness, duration, and intensity;

viii. play, including structure, content, symbolic functioning, and modulation of aggression;

ix. cognitive functioning; and

x. relatedness to parents, other caregivers, and examiner; and

(c) other assessment tools as determined and periodically revised by the commissioner;

(2) for children ages 5 to 18, completion of other assessment standards for children as determined and periodically revised by the commissioner; and

(3) for adults, completion of other assessment standards for adults as determined and periodically revised by the commissioner.

D. A brief diagnostic assessment must include a face-to-face interview with the client and a written evaluation of the client by a mental health professional or practitioner working under clinical supervision as a clinical trainee according to part 9505.0371, subpart 5, item C. The professional or practitioner must gather initial background information using the components of a standard diagnostic assessment in item B, subitems (1), (2), unit (b), (3), and (5), and draw a provisional clinical hypothesis. The clinical hypothesis may be used to address the client's immediate needs or presenting problem. Treatment sessions conducted under authorization of a brief assessment may be used to gather additional information necessary to complete a standard diagnostic assessment or an extended diagnostic assessment.

E. Adult diagnostic assessment update includes a face-to-face interview with the client, and contains a written evaluation of the client by a mental health professional or practitioner working under clinical supervision as a clinical trainee according to part 9505.0371, subpart 5, item C, who reviews a standard or extended diagnostic assessment. The adult diagnostic assessment update must update the most recent assessment document in writing in the following areas:

(1) review of the client's life situation, including an interview with the client about the client's current life situation, and a written update of those parts where significant new or changed information exists, and documentation where there has not been significant change;

(2) review of the client's presenting problems, including an interview with the client about current presenting problems and a written update of those parts where there is significant new or changed information, and note parts where there has not been significant change;

(3) screenings for substance use, abuse, or dependency and other screenings as determined by the commissioner;

(4) the client's mental health status examination;

(5) assessment of client's needs based on the client's baseline measurements, symptoms, behavior, skills, abilities, resources, vulnerabilities, and safety needs;

(6) the client's clinical summary, recommendations, and prioritization of needed mental health, ancillary, or other services, client and family participation in assessment and service preferences, and referrals to services required by statute or rule; and

(7) the client's diagnosis on all axes of the current edition of the Diagnostic and Statistical Manual and any differential diagnosis.

Subp. 2. **Neuropsychological assessment.** A neuropsychological assessment must include a face-to-face interview with the client, the interpretation of the test results, and preparation and completion of a report. A client is eligible for a neuropsychological assessment if at least one of the following criteria is met:

A. There is a known or strongly suspected brain disorder based on medical history or neurological evaluation such as a history of significant head trauma, brain tumor, stroke, seizure disorder, multiple sclerosis, neurodegenerative disorders, significant exposure to neurotoxins, central nervous system infections, metabolic or toxic encephalopathy, fetal alcohol syndrome, or congenital malformations of the brain; or

B. In the absence of a medically verified brain disorder based on medical history or neurological evaluation, there are cognitive or behavioral symptoms that suggest that the client has an organic condition that cannot be readily attributed to functional psychopathology, or suspected neuropsychological impairment in addition to functional psychopathology. Examples include:

(1) poor memory or impaired problem solving;

(2) change in mental status evidenced by lethargy, confusion, or disorientation;

(3) deterioration in level of functioning;

(4) marked behavioral or personality change;

(5) in children or adolescents, significant delays in academic skill acquisition or poor attention relative to peers;

(6) in children or adolescents, significant plateau in expected development of cognitive, social, emotional, or physical function, relative to peers; and

(7) in children or adolescents, significant inability to develop expected knowledge, skills, or abilities as required to adapt to new or changing cognitive, social, emotional, or physical demands.

C. If neither criterion in item A nor B is fulfilled, neuropsychological evaluation is not indicated.

D. The neuropsychological assessment must be conducted by a neuropsychologist with competence in the area of neuropsychological assessment as stated to the Minnesota Board of Psychology who:

(1) was awarded a diploma by the American Board of Clinical Neuropsychology, the American Board of Professional Neuropsychology, or the American Board of Pediatric Neuropsychology;

(2) earned a doctoral degree in psychology from an accredited university training program:

(a) completed an internship, or its equivalent, in a clinically relevant area of professional psychology;

(b) completed the equivalent of two full-time years of experience and specialized training, at least one which is at the postdoctoral level, in the study and practices of clinical neuropsychology and related neurosciences supervised by a clinical neuropsychologist; and

(c) holds a current license to practice psychology independently in accordance with Minnesota Statutes, sections 148.88 to 148.98;

(3) is licensed or credentialed by another state's board of psychology examiners in the specialty of neuropsychology using requirements equivalent to requirements specified by one of the boards named in subitem (1); or

(4) was approved by the commissioner as an eligible provider of neuropsychological assessment prior to December 31, 2010.

Subp. 3. **Neuropsychological testing.**

A. Medical assistance covers neuropsychological testing when the client has either:

(1) a significant mental status change that is not a result of a metabolic disorder that has failed to respond to treatment;

(2) in children or adolescents, a significant plateau in expected development of cognitive, social, emotional, or physical function, relative to peers;

(3) in children or adolescents, significant inability to develop expected knowledge, skills, or abilities, as required to adapt to new or changing cognitive, social, physical, or emotional demands; or

(4) a significant behavioral change, memory loss, or suspected neuropsychological impairment in addition to functional psychopathology, or other organic brain injury or one of the following:

(a) traumatic brain injury;

(b) stroke;

(c) brain tumor;

(d) substance abuse or dependence;

(e) cerebral anoxic or hypoxic episode;

(f) central nervous system infection or other infectious disease;

(g) neoplasms or vascular injury of the central nervous system;

(h) neurodegenerative disorders;

(i) demyelinating disease;

(j) extrapyramidal disease;

(k) exposure to systemic or intrathecal agents or cranial radiation known to be associated with cerebral dysfunction;

(l) systemic medical conditions known to be associated with cerebral dysfunction, including renal disease, hepatic encephalopathy, cardiac anomaly, sickle cell disease, and related hematologic anomalies, and autoimmune disorders such as lupus, erythematosis, or celiac disease;

(m) congenital genetic or metabolic disorders known to be associated with cerebral dysfunction, such as phenylketonuria, craniofacial syndromes, or congenital hydrocephalus;

(n) severe or prolonged nutrition or malabsorption syndromes; or

(o) a condition presenting in a manner making it difficult for a clinician to distinguish between:

i. the neurocognitive effects of a neurogenic syndrome such as dementia or encephalopathy; and

ii. a major depressive disorder when adequate treatment for major depressive disorder has not resulted in improvement in neurocognitive function, or another disorder such as autism, selective mutism, anxiety disorder, or reactive attachment disorder.

B. Neuropsychological testing must be administered or clinically supervised by a neuropsychologist qualified as defined in subpart 2, item D.

C. Neuropsychological testing is not covered when performed:

(1) primarily for educational purposes;

(2) primarily for vocational counseling or training;

(3) for personnel or employment testing;

(4) as a routine battery of psychological tests given at inpatient admission or continued stay; or

(5) for legal or forensic purposes.

Subp. 4. **Psychological testing.** Psychological testing must meet the following requirements:

A. The psychological testing must:

(1) be administered or clinically supervised by a licensed psychologist with competence in the area of psychological testing as stated to the Minnesota Board of Psychology; and

(2) be validated in a face-to-face interview between the client and a licensed psychologist or a mental health practitioner working as a clinical psychology trainee as required by part 9505.0371, subpart 5, item C, under the clinical supervision of a licensed psychologist according to part 9505.0371, subpart 5, item A, subitem (2).

B. The administration, scoring, and interpretation of the psychological tests must be done under the clinical supervision of a licensed psychologist when performed by a technician, psychometrist, or psychological assistant or as part of a computer-assisted psychological testing program.

C. The report resulting from the psychological testing must be:

(1) signed by the psychologist conducting the face-to-face interview;

(2) placed in the client's record; and

(3) released to each person authorized by the client.

Subp. 5. **Explanations of findings.** To be eligible for medical assistance payment, the mental health professional providing the explanation of findings must obtain the authorization of the client or the client's representative to release the information as required in part 9505.0371, subpart 6. Explanation of findings is provided to the client, client's family, and caregivers, or to other providers to help them understand the results of the testing or diagnostic assessment, better understand the client's illness, and provide professional insight needed to carry out a plan of treatment. An explanation of findings is not paid separately when the results of psychological testing or a diagnostic assessment are explained to the client or the client's representative as part of the psychological testing or a diagnostic assessment.

Subp. 6. **Psychotherapy.** Medical assistance covers psychotherapy as conducted by a mental health professional or a mental health practitioner as defined in part 9505.0371, subpart 5, item C, as provided in this subpart.

A. Individual psychotherapy is psychotherapy designed for one client.

B. Family psychotherapy is designed for the client and one or more family members or the client's primary caregiver whose participation is necessary to accomplish the client's treatment goals. Family members or primary caregivers participating in a therapy session do not need to be eligible for medical assistance. For purposes of this subpart, the phrase "whose participation is necessary to accomplish the client's treatment goals" does not include shift or facility staff members at the client's residence. Medical assistance payment for family psychotherapy is limited to face-to-face sessions at which the client is present throughout the family psychotherapy session unless the mental health professional believes

the client's absence from the family psychotherapy session is necessary to carry out the client's individual treatment plan. If the client is excluded, the mental health professional must document the reason for and the length of time of the exclusion. The mental health professional must also document the reason or reasons why a member of the client's family is excluded.

C. Group psychotherapy is appropriate for individuals who because of the nature of their emotional, behavioral, or social dysfunctions can derive mutual benefit from treatment in a group setting. For a group of three to eight persons, one mental health professional or practitioner is required to conduct the group. For a group of nine to 12 persons, a team of at least two mental health professionals or two mental health practitioners or one mental health professional and one mental health practitioner is required to co-conduct the group. Medical assistance payment is limited to a group of no more than 12 persons.

D. A multiple-family group psychotherapy session is eligible for medical assistance payment if the psychotherapy session is designed for at least two but not more than five families. Multiple-family group psychotherapy is clearly directed toward meeting the identified treatment needs of each client as indicated in client's treatment plan. If the client is excluded, the mental health professional or practitioner must document the reason for and the length of the time of the exclusion. The mental health professional or practitioner must document the reasons why a member of the client's family is excluded.

Subp. 7. **Medication management.** The determination or evaluation of the effectiveness of a client's prescribed drug must be carried out by a physician or by an advanced practice registered nurse, as defined in Minnesota Statutes, sections 148.171 to 148.285, who is qualified in psychiatric nursing.

Subp. 8. **Adult day treatment.** Adult day treatment payment limitations include the following conditions.

A. Adult day treatment must consist of at least one hour of group psychotherapy, and must include group time focused on rehabilitative interventions, or other therapeutic services that are provided by a multidisciplinary staff. Adult day treatment is an intensive psychotherapeutic treatment. The services must stabilize the client's mental health status, and develop and improve the client's independent living and socialization skills. The goal of adult day treatment is to reduce or relieve the effects of mental illness so that an individual is able to benefit from a lower level of care and to enable the client to live and function more independently in the community. Day treatment services are not a part of inpatient or residential treatment services.

B. To be eligible for medical assistance payment, a day treatment program must:

(1) be reviewed by and approved by the commissioner;

(2) be provided to a group of clients by a multidisciplinary staff under the clinical supervision of a mental health professional;

(3) be available to the client at least two days a week for at least three consecutive hours per day. The day treatment may be longer than three hours per day, but medical assistance must not reimburse a provider for more than 15 hours per week;

(4) include group psychotherapy done by a mental health professional, or mental health practitioner qualified according to part 9505.0371, subpart 5, item C, and rehabilitative interventions done by a mental health professional or mental health practitioner daily;

(5) be included in the client's individual treatment plan as necessary and appropriate. The individual treatment plan must include attainable, measurable goals as they relate to services and must be completed before the first day treatment session. The vendor must review the recipient's progress and update the treatment plan at least every 30 days until the client is discharged and include an available discharge plan for the client in the treatment plan; and

(6) document the interventions provided and the client's response daily.

C. To be eligible for adult day treatment, a recipient must:

(1) be 18 years of age or older;

(2) not be residing in a nursing facility, hospital, institute of mental disease, or regional treatment center, unless the recipient has an active discharge plan that indicates a move to an independent living arrangement within 180 days;

(3) have a diagnosis of mental illness as determined by a diagnostic assessment;

(4) have the capacity to engage in the rehabilitative nature, the structured setting, and the therapeutic parts of psychotherapy and skills activities of a day treatment program and demonstrate measurable improvements in the recipient's functioning related to the recipient's mental illness that would result from participating in the day treatment program;

(5) have at least three areas of functional impairment as determined by a functional assessment with the domains prescribed by Minnesota Statutes, section 245.462, subdivision 11a;

(6) have a level of care determination that supports the need for the level of intensity and duration of a day treatment program; and

(7) be determined to need day treatment by a mental health professional who must deem the day treatment services medically necessary.

D. The following services are not covered by medical assistance if they are provided by a day treatment program:

(1) a service that is primarily recreation-oriented or that is provided in a setting that is not medically supervised. This includes: sports activities, exercise groups, craft hours, leisure time, social hours, meal or snack time, trips to community activities, and tours;

(2) a social or educational service that does not have or cannot reasonably be expected to have a therapeutic outcome related to the client's mental illness;

(3) consultation with other providers or service agency staff about the care or progress of a client;

(4) prevention or education programs provided to the community;

(5) day treatment for recipients with primary diagnoses of alcohol or other drug abuse;

(6) day treatment provided in the client's home;

(7) psychotherapy for more than two hours daily; and

(8) participation in meal preparation and eating that is not part of a clinical treatment plan to address the client's eating disorder.

Subp. 9. **Partial hospitalization.** Partial hospitalization is a covered service when it is an appropriate alternative to inpatient hospitalization for a client who is experiencing an acute episode of mental illness that meets the criteria for an inpatient hospital admission as specified in part 9505.0520, subpart 1, and who has the family and community resources necessary and appropriate to support the client's residence in the community. Partial hospitalization consists of multiple intensive short-term therapeutic services provided by a multidisciplinary staff to treat the client's mental illness.

Subp. 10. **Dialectical behavior therapy (DBT).** Dialectical behavior therapy (DBT) treatment services must meet the following criteria:

A. DBT must be provided according to this subpart and Minnesota Statutes, section 256B.0625, subdivision 5l.

B. DBT is an outpatient service that is determined to be medically necessary by either: (1) a mental health professional qualified according to part 9505.0371, subpart 5, or (2) a mental health practitioner working as a clinical trainee according to part 9505.0371, subpart 5, item C, who is under the clinical supervision of a mental health professional according to part 9505.0371, subpart 5, item D, with specialized skill in dialectical behavior therapy. The treatment recommendation must be based upon a comprehensive evaluation that includes a diagnostic assessment and functional assessment of the client, and review of the client's prior treatment history. Treatment services must be provided pursuant to the client's individual treatment plan and provided to a client who satisfies the criteria in item C.

C. To be eligible for DBT, a client must:

(1) be 18 years of age or older;

(2) have mental health needs that cannot be met with other available community-based services or that must be provided concurrently with other community-based services;

(3) meet one of the following criteria:

(a) have a diagnosis of borderline personality disorder; or

(b) have multiple mental health diagnoses and exhibit behaviors characterized by impulsivity, intentional self-harm behavior, and be at significant risk of death, morbidity, disability, or severe dysfunction across multiple life areas;

(4) understand and be cognitively capable of participating in DBT as an intensive therapy program and be able and willing to follow program policies and rules assuring safety of self and others; and

(5) be at significant risk of one or more of the following if DBT is not provided:

(a) mental health crisis;

(b) requiring a more restrictive setting such as hospitalization;

(c) decompensation; or

(d) engaging in intentional self-harm behavior.

D. The treatment components of DBT are individual therapy and group skills as follows:

(1) Individual DBT combines individualized rehabilitative and psychotherapeutic interventions to treat suicidal and other dysfunctional behaviors and reinforce the use of adaptive skillful behaviors. The therapist must:

(a) identify, prioritize, and sequence behavioral targets;

(b) treat behavioral targets;

(c) generalize DBT skills to the client's natural environment through telephone coaching outside of the treatment session;

(d) measure the client's progress toward DBT targets;

(e) help the client manage crisis and life-threatening behaviors; and

(f) help the client learn and apply effective behaviors when working with other treatment providers.

(2) Individual DBT therapy is provided by a mental health professional or a mental health practitioner working as a clinical trainee, according to part 9505.0371, subpart 5, item C, under the supervision of a licensed mental health professional according to part 9505.0371, subpart 5, item D.

(3) Group DBT skills training combines individualized psychotherapeutic and psychiatric rehabilitative interventions conducted in a group format to reduce the client's suicidal and other dysfunctional coping behaviors and restore function by teaching the client adaptive skills in the following areas:

(a) mindfulness;

(b) interpersonal effectiveness;

(c) emotional regulation; and

(d) distress tolerance.

(4) Group DBT skills training is provided by two mental health professionals, or by a mental health professional cofacilitating with a mental health practitioner.

(5) The need for individual DBT skills training must be determined by a mental health professional or a mental health practitioner working as a clinical trainee, according to part 9505.0371, subpart 5, item C, under the supervision of a licensed mental health professional according to part 9505.0371, subpart 5, item D.

E. A program must be certified by the commissioner as a DBT provider. To qualify for certification, a provider must:

(1) hold current accreditation as a DBT program from a nationally recognized certification body approved by the commissioner or submit to the commissioner's inspection and provide evidence that the DBT program's policies, procedures, and practices will continuously meet the requirements of this subpart;

(2) be enrolled as a MHCP provider;

(3) collect and report client outcomes as specified by the commissioner; and

(4) have a manual that outlines the DBT program's policies, procedures, and practices which meet the requirements of this subpart.

F. The DBT treatment team must consist of persons who are trained in DBT treatment. The DBT treatment team may include persons from more than one agency. Professional and clinical affiliations with the DBT team must be delineated:

(1) A DBT team leader must:

(a) be a mental health professional employed by, affiliated with, or contracted by a DBT program certified by the commissioner;

(b) have appropriate competencies and working knowledge of the DBT principles and practices; and

(c) have knowledge of and ability to apply the principles and DBT practices that are consistent with evidence-based practices.

(2) DBT team members who provide individual DBT or group skills training must:

(a) be a mental health professional or be a mental health practitioner, who is employed by, affiliated with, or contracted with a DBT program certified by the commissioner;

(b) have or obtain appropriate competencies and working knowledge of DBT principles and practices within the first six months of becoming a part of the DBT program;

(c) have or obtain knowledge of and ability to apply the principles and practices of DBT consistently with evidence-based practices within the first six months of working at the DBT program;

(d) participate in DBT consultation team meetings; and

(e) require mental health practitioners to have ongoing clinical supervision by a mental health professional who has appropriate competencies and working knowledge of DBT principles and practices.

Subp. 11. **Noncovered services.** The mental health services in items A to J are not eligible for medical assistance payment under this part:

A. a mental health service that is not medically necessary;

B. a neuropsychological assessment carried out by a person other than a neuropsychologist who is qualified according to part 9505.0372, subpart 2, item D;

C. a service ordered by a court that is solely for legal purposes and not related to the recipient's diagnosis or treatment for mental illness;

D. services dealing with external, social, or environmental factors that do not directly address the recipient's physical or mental health;

E. a service that is only for a vocational purpose or an educational purpose that is not mental health related;

F. staff training that is not related to a client's individual treatment plan or plan of care;

G. child and adult protection services;

H. fund-raising activities;

I. community planning; and

J. client transportation.

9520.0010 STATUTORY AUTHORITY AND PURPOSE.

Parts 9520.0010 to 9520.0230 provide methods and procedures relating to the establishment and operation of area-wide, comprehensive, community-based mental health, developmental disability, and chemical dependency programs under state grant-in-aid as provided under Minnesota Statutes, sections 245.61 to 245.69. Minnesota Statutes, sections 245.61 to 245.69 are entitled The Community Mental Health Services Act. For purposes of these parts, "community mental health services" includes services to persons who have mental or emotional disorders or other psychiatric disabilities, developmental disabilities, and chemical dependency, including drug abuse and alcoholism.

9520.0020 BOARD DUTIES.

The community mental health board has the responsibility for ensuring the planning, development, implementation, coordination, and evaluation of the community comprehensive mental health program for the mentally ill/behaviorally disabled, developmentally disabled, and chemically dependent populations in the geographic area it serves. It also has the responsibility for ensuring delivery of services designated by statute.

9520.0030 DEFINITIONS.

Parts 9520.0040 and 9520.0050 also set forth definitions of community mental health centers and community mental health clinics.

9520.0040 COMMUNITY MENTAL HEALTH CENTER.

A community mental health center means an agency which includes all of the following:

A. Established under the provision of Minnesota Statutes, sections 245.61 to 245.69.

B. Provides as a minimum the following services for individuals with mental or emotional disorders, developmental disabilities, alcoholism, drug abuse, and other psychiatric conditions. The extent of each service to be provided by the center shall be indicated in the program plan, which is to reflect the problems, needs, and resources of the community served:

(1) collaborative and cooperative services with public health and other groups for programs of prevention of mental illness, developmental disability, alcoholism, drug abuse, and other psychiatric disorders;

(2) informational and educational services to schools, courts, health and welfare agencies, both public and private;

(3) informational and educational services to the general public, lay, and professional groups;

(4) consultative services to schools, courts, and health and welfare agencies, both public and private;

(5) outpatient diagnostic and treatment services; and

(6) rehabilitative services, particularly for those who have received prior treatment in an inpatient facility.

C. Provides or contracts for detoxification, evaluation, and referral for chemical dependency services (Minnesota Statutes, section 254A.08).

D. Provides specific coordination for mentally ill/behaviorally disabled, developmental disability, and chemical dependency programs. (Minnesota Statutes, sections 254A.07 and 245.61).

E. Has a competent multidisciplinary mental health/developmental disability/chemical dependency professional team whose members meet the professional standards in their respective fields.

F. The professional mental health team is qualified by specific mental health training and experience and shall include as a minimum the services of each of the following:

(1) a licensed physician, who has completed an approved residency program in psychiatry; and

(2) a doctoral clinical, counseling, or health care psychologist, who is licensed under Minnesota Statutes, sections 148.88 to 148.98; and one or both of the following:

(3) a clinical social worker with a master's degree in social work from an accredited college or university; and/or

(4) a clinical psychiatric nurse with a master's degree from an accredited college or university and is registered under Minnesota Statutes, section 148.171. The master's degree shall be in psychiatric nursing or a related psychiatric nursing program such as public health nursing with mental health major, maternal and child health with mental health major, etc.

G. The multidisciplinary staff shall be sufficient in number to implement and operate the described program of the center. In addition to the above, this team should include other professionals, paraprofessionals, and disciplines, particularly in the preventive and rehabilitative components of the program, subject to review and approval of job descriptions and qualifications by the commissioner. If any of the minimum required professional staff are not immediately available, the commissioner may approve and make grants for the operation of the center, provided that the board and director can show evidence acceptable to the commissioner that they are making sincere, reasonable, and ongoing efforts

to acquire such staff and show evidence of how the specialized functions of the required professionals are being met. The services being rendered by employed personnel shall be consistent with their professional discipline.

9520.0050 COMMUNITY MENTAL HEALTH CLINIC.

Subpart 1. **Definitions.** A community mental health clinic is an agency which devotes, as its major service, at least two-thirds of its resources for outpatient mental health diagnosis, treatment, and consultation by a multidisciplinary professional mental health team. The multidisciplinary professional mental health team is qualified by special mental health training and experience and shall include as a minimum the services of each of the following:

A. a licensed physician, who has completed an approved residency program in psychiatry; and

B. a doctoral clinical, or counseling or health care psychologist who is licensed under Minnesota Statutes, sections 148.88 to 148.98; and one or both of the following:

C. a clinical social worker with a master's degree in social work from an accredited college or university; and/or

D. a clinical psychiatric nurse with a master's degree from an accredited college or university and is registered under Minnesota Statutes, section 148.171. The master's degree shall be in psychiatric nursing or a related psychiatric nursing program such as public health with a mental health major, maternal and child health with a mental health major.

Subp. 2. **Other members of multidisciplinary team.** The multidisciplinary team shall be sufficient in number to implement and operate the described program of the clinic. In addition to the above, this team should include other professionals, paraprofessionals and disciplines, particularly in the preventive and rehabilitative components of the program, subject to review and approval of job descriptions and qualifications by the commissioner.

Subp. 3. **Efforts to acquire staff.** If any of the minimum required professional staff are not immediately available, the commissioner may approve and make grants for the operation of the clinic, provided that the board and director can show evidence acceptable to the commissioner that they are making sincere, reasonable, and ongoing efforts to acquire such staff and evidence of how the specialized functions of the required professional positions are being met. The services being rendered by employed personnel shall be consistent with their professional discipline.

9520.0060 ANNUAL PLAN AND BUDGET.

On or before the date designated by the commissioner, each year the chair of the community mental health board or director of the community mental health program, provided for in Minnesota Statutes, section 245.62, shall submit an annual plan identifying program priorities in accordance with state grant-in-aid guidelines, and a budget on prescribed report forms for the next state fiscal year, together with the recommendations of the community mental health board, to the commissioner of human services for approval as provided under Minnesota Statutes, section 245.63.

9520.0070 FISCAL AFFILIATES.

Other providers of community mental health services may affiliate with the community mental health center and may be approved and eligible for state grant-in-aid funds. The state funding for other community mental health services shall be contingent upon appropriate inclusion in the center's community mental health plan for the continuum of community mental health services and conformity with the state's appropriate disability plan for mental health, developmental disability, or chemical dependency. Fiscal affiliates (funded contracting agencies) providing specialized services under contract must meet all rules and standards that apply to the services they are providing.

9520.0080 OTHER REQUIRED REPORTS.

The program director of the community mental health program shall provide the commissioner of human services with such reports of program activities as the commissioner may require.

9520.0090 FUNDING.

All state community mental health funding shall go directly to the community mental health board or to a human service board established pursuant to Laws of Minnesota 1975, chapter 402, which itself provides or contracts with another agency to provide the community mental health program. Such programs must meet the standards and rules for community mental health programs as enunciated in parts 9520.0010 to 9520.0230 in accordance with Laws of Minnesota 1975, chapter 402.

9520.0100 OPERATION OF OTHER PROGRAMS.

When the governing authority of the community mental health program operates other programs, services, or activities, only the community mental health center program shall be subject to these parts.

9520.0110 APPLICATIONS AND AGREEMENTS BY LOCAL COUNTIES.

New applications for state assistance or applications for renewal of support must be accompanied by an agreement executed by designated signatories on behalf of the participating counties that specifies the involved counties, the amount and source of local funds in each case, and the period of support. The local funds to be used to match state grant-in-aid must be assured in writing on Department of Human Services forms by the local funding authority(ies).

9520.0120 USE OF MATCHING FUNDS.

Funds utilized by the director as authorized by the community mental health board to match a state grant-in-aid must be available to that director for expenditures for the same general purpose as the state grant-in-aid funds.

9520.0130 QUARTERLY REPORTS.

The director of the community mental health program shall, within 20 days after the end of the quarter, submit quarterly prescribed reports to the commissioner of human services (controller's office), containing all receipts, expenditures, and cash balance, subject to an annual audit by the commissioner or his/her designee.

9520.0140 PAYMENTS.

Payments on approved grants will be made subsequent to the department's receipt of the program's quarterly reporting forms, unless the commissioner of human services has determined that funds allocated to a program are not needed for that program. Payments shall be in an amount of at least equal to the quarterly allocation minus any unexpended balance from the previous quarter providing this payment does not exceed the program grant award. In the event the program does not report within the prescribed time, the department will withhold the process of the program's payment until the next quarterly cycle.

9520.0150 FEES.

No fees shall be charged until the director with approval of the community mental health board has established fee schedules for the services rendered and they have been submitted to the commissioner of human services at least two months prior to the effective date thereof and have been approved by him/her. All fees shall conform to the approved schedules, which are accessible to the public.

9520.0160 SUPPLEMENTAL AWARDS.

The commissioner of human services may make supplemental awards to the community mental health boards.

9520.0170 WITHDRAWAL OF FUNDS.

The commissioner of human services may withdraw funds from any program that is not administered in accordance with its approved plan and budget. Written notice of such intended action will be provided to the director and community mental health board. Opportunity for hearing before the commissioner or his/her designee shall be provided.

9520.0180 BUDGET TRANSFERS.

Community mental health boards may make budget transfers within specified limits during any fiscal year without prior approval of the department. The specified limit which can be transferred in any fiscal year between program activity budgets shall be up to ten percent or up to $5,000 whichever is less. Transfers within an activity can be made into or out of line items with a specified limit of up to ten percent or up to $5,000 whichever is less. No line item can be increased or decreased by more than $5,000 or ten percent in a fiscal year without prior approval of the commissioner. Transfers above the specified limits can be made with prior approval from the commissioner. All transfers within and into program budget activities and/or line items must have prior approval by the community mental health board and this approval must be reflected in the minutes of its meeting, it must be reported to the commissioner with the reasons therefor, including a statement of how the transfer will affect program objectives.

9520.0190 BUDGET ADJUSTMENTS.

Budget adjustments made necessary by funding limitations shall be made by the commissioner and provided in writing to the director and board of the community mental health center.

9520.0200 CENTER DIRECTOR.

Every community mental health board receiving state funds for a community mental health program shall have a center director, who is the full-time qualified professional staff member who serves as the executive officer. To be considered qualified, the individual must have professional training to at least the level of graduate degree in his/her clinical and/or administrative discipline, which is relevant to MH-DD-CD and a minimum of two years experience in community mental health programs. The center director is responsible for the planning/design, development, coordination, and evaluation of a comprehensive, area-wide program and for the overall administration of services operated by the board.

The center director shall be appointed by the community mental health board and shall be approved by the commissioner of human services.

9520.0210 DEADLINE FOR APPROVAL OR DENIAL OF REQUEST FOR APPROVAL STATUS.

The commissioner shall approve or deny, in whole or in part, an application for state financial assistance within 90 days of receipt of the grant-in-aid application or by the beginning of the state fiscal year, whichever is the later.

9520.0230 ADVISORY COMMITTEE.

Subpart 1. **Purpose.** To assist the community mental health board in meeting its responsibilities as described in Minnesota Statutes, section 245.68 and to provide opportunity for broad community representation necessary for effective comprehensive mental health, developmental disability, and chemical dependency program planning, each community

mental health board shall appoint a separate advisory committee in at least the three disability areas of mental health, developmental disability, and chemical dependency.

Subp. 2. **Membership.** The advisory committees shall consist of residents of the geographic area served who are interested and knowledgeable in the area governed by such committee.

Subp. 3. **Nominations for membership.** Nominations for appointments as members of the advisory committees are to be made to the community mental health board from agencies, organizations, groups, and individuals within the area served by the community mental health center. Appointments to the advisory committees are made by the community mental health board.

Subp. 4. **Board member on committee.** One community mental health board member shall serve on each advisory committee.

Subp. 5. **Nonprovider members.** Each advisory committee shall have at least one-half of its membership composed of individuals who are not providers of services to the three disability groups.

Subp. 6. **Representative membership.** Membership of each advisory committee shall generally reflect the population distribution of the service delivery area of the community mental health center.

Subp. 7. **Chairperson appointed.** The community mental health board shall appoint a chairperson for each advisory committee. The chairperson shall not be a community mental health board member nor a staff member. The power to appoint the chairperson may be delegated by the community mental health board to the individual advisory committee.

Subp. 8. **Committee responsibility to board.** Each advisory committee shall be directly responsible to the community mental health board. Direct communication shall be effected and maintained through contact between the chairperson of the particular advisory committee, or his/her designee, and the chairperson of the community mental health board, or his/her designee.

Subp. 9. **Staff.** Staff shall be assigned by the director to serve the staffing needs of each advisory committee.

Subp. 10. **Study groups and task forces.** Each advisory committee may appoint study groups and task forces upon consultation with the community mental health board. It is strongly recommended that specific attention be given to the aging and children and youth populations.

Subp. 11. **Quarterly meetings required.** Each advisory committee shall meet at least quarterly.

Subp. 12. **Annual report required.** Each advisory committee must make a formal written and oral report on its work to the community mental health board at least annually.

Subp. 13. **Minutes.** Each advisory committee shall submit copies of minutes of their meetings to the community mental health board and to the Department of Human Services (respective disability group program divisions).

Subp. 14. **Duties of advisory committee.** The advisory committees shall be charged by the community mental health board with assisting in the identification of the community's needs for mentally ill/behaviorally disabled, developmental disability, and chemical dependency programs. The advisory committee also assists the community mental health board in determining priorities for the community programs. Based on the priorities, each advisory committee shall recommend to the community mental health board ways in which the limited available community resources (work force, facilities, and finances) can be put to maximum and optimal use.

Subp. 15. **Recommendations.** The advisory committee recommendations made to the community mental health board shall be included as a separate section in the grant-in-aid request submitted to the Department of Human Services by the community mental health board.

Subp. 16. **Assessment of programs.** The advisory committees shall assist the community mental health board in assessing the programs carried on by the community mental health board, and make recommendations regarding the reordering of priorities and modifying of programs where necessary.

9549.0057 DETERMINATION OF INTERIM AND SETTLE UP OPERATING COST PAYMENT RATES.

Subpart 1. **Conditions.** To receive an interim payment rate, a nursing facility must comply with the requirements and is subject to the conditions in part 9549.0060, subpart 14, items A to C. The commissioner shall determine interim and settle up operating cost payment rates for a newly constructed nursing facility, or one with an increase in licensed capacity of 50 percent or more according to subparts 2 and 3.

Subp. 2. **Interim operating cost payment rate.** For the rate year or portion of an interim period beginning on or after July 1, 1986, the interim total operating cost payment rate must be determined according to parts 9549.0050 to 9549.0059 (Temporary) in effect on March 1, 1987. For the rate year or portion of an interim period beginning on or after July 1, 1987, the interim total operating cost payment rate must be determined according to parts 9549.0051 to 9549.0059, except that:

A. The nursing facility must project its anticipated resident days for each resident class. The anticipated resident days for each resident class must be multiplied by the weight for that resident class as listed in part 9549.0058 to determine the anticipated standardized resident days for the reporting period.

B. The commissioner shall use anticipated standardized resident days in determining the allowable historical case mix operating cost standardized per diem.

C. The commissioner shall use the anticipated resident days in determining both the allowable historical other care related operating cost per diem and the allowable historical other operating cost per diem.

D. The annual adjustment factors determined in part 9549.0055, subpart 1, must not be applied to the nursing facility's allowable historical per diems as provided in part 9549.0056, subparts 2 and 4.

E. The limits established in part 9549.0055, subpart 2, items C and E, as indexed in part 9549.0055, subpart 3 and in effect at the beginning of the interim period, must be increased by ten percent.

F. The efficiency incentive in part 9549.0056, subpart 4, item A or B, must not apply.

G. The phase in provisions in part 9549.0056, subpart 7, must not apply.

Subp. 3. **Settle up operating cost payment rate.** The settle up total operating cost payment rate must be determined according to items A to C.

A. The settle up operating cost payment rate for interim periods before July 1, 1987, is subject to the rule parts that were in effect during the interim period.

B. To determine the settle up operating cost payment rate for interim periods or the portion of an interim period occurring after July 1, 1987, subitems (1) to (7) must be applied.

(1) The standardized resident days as determined in part 9549.0054, subpart 2, must be used for the interim period.

(2) The commissioner shall use the standardized resident days in subitem (1) in determining the allowable historical case mix operating cost standardized per diem.

(3) The commissioner shall use the actual resident days in determining both the allowable historical other care related operating cost per diem and the allowable historical other operating cost per diem.

(4) The annual adjustment factors determined in part 9549.0055, subpart 1, must not be applied to the nursing facility's allowable historical per diems as provided in part 9549.0056, subparts 2 and 4.

(5) The limits established in part 9549.0055, subpart 2, item E, must be the limits for the settle up reporting periods occurring after July 1, 1987. If the interim period includes more than one July 1 date, the commissioner shall use the limit established in part 9549.0055, subpart 2, items C and E, as indexed in part 9549.0055, subpart 3, increased by ten percent for the second July 1 date.

(6) The efficiency incentive in part 9549.0056, subpart 4, item A or B, must not apply.

(7) The phase in provisions in part 9549.0056, subpart 7 must not apply.

C. For the nine month period following the settle up reporting period, the total operating cost payment rate must be determined according to item B except that the efficiency incentive as computed in part 9549.0056, subpart 4, item A or B, applies.

D. The total operating cost payment rate for the rate year beginning July 1 following the nine month period in item C must be determined under parts 9549.0050 to 9549.0059.

E. A newly constructed nursing facility or one with an increase in licensed capacity of 50 percent or more must continue to receive the interim total operating cost payment rate until the settle up total operating cost payment rate is determined under this subpart.

9549.0060 DETERMINATION OF THE PROPERTY-RELATED PAYMENT RATE.

Subp. 4. **Determination of allowable appraised value.** A nursing facility's appraised value must be limited by items A to C.

A. For rate years beginning after June 30, 1985, the replacement cost new per bed limit for licensed beds in single bedrooms and multiple bedrooms is determined according to subitems (1) to (4):

(1) Effective January 1, 1984, the replacement cost new per bed limit for licensed beds in single bedrooms is $41,251 and for licensed beds in multiple bedrooms is $27,500. On January 1, 1985, the commissioner shall adjust the replacement cost new per bed limit by the percentage change in the composite cost of construction index published by the Bureau of Economic Analysis of the United States Department of Commerce in the Survey of Current Business Statistics for the two previous Octobers. The index is incorporated by reference and is available at the James J. Hill Reference Library, Saint Paul, Minnesota.

(2) The average historical cost per bed for depreciable equipment is computed by adding the historical cost of depreciable equipment for each nursing facility as determined in subpart 10, item A, and dividing the sum by the total number of licensed beds in those nursing facilities. The amount is then subtracted from the replacement cost new per bed limits determined in subitem (1).

(3) The differences computed in subitem (2) are the replacement cost new per bed limits for licensed beds in single bedrooms and multiple bedrooms effective for the rate year beginning on July 1, 1985.

(4) On January 1, 1986, and each succeeding January 1, the commissioner shall adjust the limit in subitem (3) by the percentage change in the composite cost of

construction index published by the Bureau of Economic Analysis of the United States Department of Commerce in the Survey of Current Business Statistics for the two previous Octobers.

B. Each nursing facility's maximum allowable replacement cost new is determined annually according to subitems (1) to (3):

(1) The multiple bedroom replacement cost new per bed limit in item A must be multiplied by the number of licensed beds in multiple bedrooms.

(2) The single bedroom replacement cost new per bed limit in item A must be multiplied by the number of licensed beds in single bedrooms except as provided in subpart 11, item C, subitem (2).

(3) The nursing facility's maximum allowable replacement cost new is the sum of subitems (1) and (2).

C. The nursing facility's replacement cost new determined in subparts 1 to 3 must be reduced by the replacement cost new of portions of the nursing facility used for functions whose costs are disallowed under parts 9549.0010 to 9549.0080.

D. The adjusted replacement cost new is the lesser of item B or C.

E. The adjusted depreciation is determined by subtracting from the depreciation in subparts 1 to 3 the amount of depreciation, if any, related to the portion of the nursing facility's replacement cost new disallowed in item C or D.

F. The nursing facility's allowable appraised value is determined by subtracting the amount determined in item E from the amount in item D. If no adjustment to the replacement cost new is required in items C and D, then the nursing facility's allowable appraised value is the appraised value determined in subparts 1 to 3.

Subp. 5. **Allowable debt.** For purposes of determining the property-related payment rate, the commissioner shall allow or disallow debt according to items A to D.

A. Debt shall be limited as follows:

(1) Debt incurred for the purchase of land directly used for resident care and the purchase or construction of nursing facility buildings, attached fixtures, or land improvements or the capitalized replacement or capitalized repair of existing buildings, attached fixtures, or land improvements shall be allowed. Debt incurred for any other purpose shall not be allowed.

(2) Working capital debt shall not be allowed.

(3) An increase in the amount of a debt as a result of refinancing of capital assets which occurs after May 22, 1983, shall not be allowed except to the extent that the increase in debt is the result of refinancing costs such as points, loan origination fees, or title searches.

(4) An increase in the amount of total outstanding debt incurred after May 22, 1983, as a result of a change in ownership or reorganization of provider entities, shall not be allowed and the previous owner's allowable debt as of May 22, 1983, shall be allowed under item B.

(5) Any portion of the total allowable debt exceeding the appraised value as determined in subpart 4 shall not be allowed.

(6) Any portion of a debt of which the proceeds exceed the historical cost of the capital asset acquired shall not be allowed.

B. The nursing facility shall apportion debts incurred before October 1, 1984, among land and buildings, attached fixtures, land improvements, depreciable equipment and working capital by direct identification. If direct identification of any part of the debt is not possible, that portion of the debt which cannot be directly identified shall be

apportioned to each component, except working capital debt, based on the ratio of the historical cost of the component to the total historical cost of all components. The portion of debt assigned to land and buildings, attached fixtures, and land improvements is allowable debt.

A hospital attached nursing facility that has debts that are not directly identifiable to the hospital or the nursing facility shall allocate the portion of allowable debt computed according to subpart 5, and allowable interest expense computed according to subpart 7 assigned to land and buildings, attached fixtures, and land improvements using the Medicare stepdown method described in subpart 1.

C. For debts incurred after September 30, 1984, the nursing facility shall directly identify the proceeds of the debt associated with specific land and buildings, attached fixtures, and land improvements, and keep records that separate such debt proceeds from all other debt. Only the debt identified with specific land and buildings, attached fixtures, and land improvement shall be allowed.

D. For reporting years ending on or after September 30, 1984, the total amount of allowable debt shall be the sum of all allowable debts at the beginning of the reporting year plus all allowable debts at the end of the reporting year divided by two. Nursing facilities which have a debt with a zero balance at the beginning or end of the reporting year must use a monthly average for the reporting year.

E. Debt incurred as a result of loans between related organizations must not be allowed.

Subp. 6. **Limitations on interest rates.** The commissioner shall limit interest rates according to items A to C.

A. Except as provided in item B, the effective interest rate of each allowable debt, including points, financing charges, and amortization bond premiums or discounts, entered into after September 30, 1984, is limited to the lesser of:

(1) the effective interest rate on the debt; or

(2) 16 percent.

B. Variable or adjustable rates for allowable debt are allowed subject to item A. For each allowable debt with a variable or adjustable rate, the effective interest rate must be computed by dividing the interest expense for the reporting year by the average allowable debt computed under subpart 5, item D.

C. For rate years beginning on July 1, 1985, and July 1, 1986, the effective interest rate for debts incurred before October 1, 1984, is allowed if the interest rate is not in excess of what the borrower would have had to pay in an arms length transaction in the market in which the debt was incurred. For rate years beginning after June 30, 1987, the effective interest rate for debts incurred before October 1, 1984, is allowed subject to item A.

Subp. 7. **Allowable interest expense.** The commissioner shall allow or disallow interest expense including points, finance charges, and amortization bond premiums or discounts under items A to G.

A. Interest expense is allowed only on the debt which is allowed under subpart 5 and within the interest rate limits in subpart 6.

B. A nonprofit nursing facility shall use its restricted funds to purchase or replace capital assets to the extent of the cost of those capital assets before it borrows funds for the purchase or replacement of those capital assets. For purposes of this item and part 9549.0035, subpart 2, a restricted fund is a fund for which use is restricted to the purchase or replacement of capital assets by the donor or by the nonprofit nursing facility's board.

C. Construction period interest expense must be capitalized as a part of the cost of the building. The period of construction extends to the earlier of either the first day a

resident is admitted to the nursing facility, or the date the nursing facility is certified to receive medical assistance recipients.

D. Interest expense for allowable debts entered into after May 22, 1983, is allowed for the portion of the debt which together with all outstanding allowable debt does not exceed 100 percent of the most recent allowable appraised value as determined in subparts 1 to 4.

E. Increases in interest expense after May 22, 1983, which are the result of changes in ownership or reorganization of provider entities, are not allowable.

F. Except as provided in item G, increases in total interest expense which are the result of refinancing of debt after May 22, 1983, are not allowed. The total interest expense must be computed as the sum of the annual interest expense over the remaining term of the debt refinanced.

G. Increases in total interest expense which result from refinancing a balloon payment on allowable debt after May 22, 1983, shall be allowed according to subitems (1) to (3).

(1) The interest rate on the refinanced debt shall be limited under subpart 6, item A.

(2) The refinanced debt shall not exceed the balloon payment.

(3) The term of the refinanced debt must not exceed the term of the original debt computed as though the balloon payment did not exist.

Subp. 10. **Equipment allowance.** For rate years beginning after June 30, 1985, the equipment allowance must be computed according to items A to E.

A. The historical cost of depreciable equipment for nursing facilities which do not have costs for operating leases for depreciable equipment in excess of $10,000 during the reporting year ending September 30, 1984, is determined under subitem (1) or (2).

(1) The total historical cost of depreciable equipment reported on the nursing facility's audited financial statement for the reporting year ending September 30, 1984, must be multiplied by 70 percent. The product is the historical cost of depreciable equipment.

(2) The nursing facility may submit an analysis which classifies the historical cost of each item of depreciable equipment reported on September 30, 1984. The analysis must include an itemized description of each piece of depreciable equipment and its historical cost. The sum of the historical cost of each piece of equipment is the total historical cost of depreciable equipment for that nursing facility.

For purposes of this item, a hospital attached nursing facility shall use the allocation method in subpart 1 to stepdown the historical cost of depreciable equipment.

B. The historical cost per bed of depreciable equipment for each nursing facility must be computed by dividing the total historical cost of depreciable equipment determined in item A by the nursing facility's total number of licensed beds on September 30, 1984.

C. All nursing facilities must be grouped in one of the following:

(1) nursing facilities with total licensed beds of less than 61 beds;

(2) nursing facilities with total licensed beds of more than 60 beds and less than 101 beds; or

(3) nursing facilities with more than 100 total licensed beds.

D. Within each group determined in item C, the historical cost per bed for each nursing facility determined in item B must be ranked and the median historical cost per bed established.

E. The median historical cost per bed for each group in item C as determined in item D must be increased by ten percent. For rate years beginning after June 30, 1986, this

amount shall be adjusted annually by the percentage change indicated by the urban consumer price index for Minneapolis-Saint Paul, as published by the Bureau of Labor Statistics, new series index (1967=100) for the two previous Decembers. This index is incorporated by reference and available at the James J. Hill Reference Library, Saint Paul, Minnesota.

F. The equipment allowance for each group in item C shall be the amount computed in item E multiplied by 15 percent and divided by 350.

Subp. 11. **Capacity days.** The number of capacity days is determined under items A to C.

A. The number of capacity days is determined by multiplying the number of licensed beds in the nursing facility by the number of days in the nursing facility's reporting period.

B. Except as in item C, nursing facilities shall increase the number of capacity days by multiplying the number of licensed single bedrooms by 0.5 and by the number of days in the nursing facility's reporting period.

C. The commissioner shall waive the requirements of item B if a nursing facility agrees in writing to subitems (1) to (3).

(1) The nursing facility shall agree not to request a private room payment in part 9549.0070, subpart 3 for any of its medical assistance residents in licensed single bedrooms.

(2) The nursing facility shall agree not to use the single bedroom replacement cost new limit for any of its licensed single bedrooms in the computation of the allowable appraised value in subpart 4.

(3) The nursing facility shall agree not to charge any private paying resident in a single bedroom a payment rate that exceeds the amount calculated under units (a) to (c).

(a) The nursing facility's average total payment rate shall be determined by multiplying the total payment rate for each case mix resident class by the number of resident days for that class in the nursing facility's reporting year and dividing the sum of the resident class amounts by the total number of resident days in the nursing facility's reporting year.

(b) The nursing facility's maximum single bedroom adjustment must be determined by multiplying its average total payment rate calculated under unit (a) by ten percent.

(c) The nursing facility's single bedroom adjustment which must not exceed the amount computed in unit (b) must be added to each total payment rate established in Minnesota Statutes, sections 256B.431, 256B.434, and 256B.441, to determine the nursing facility's single bedroom payment rates.

Subp. 14. **Determination of interim and settle-up payment rates.** The commissioner shall determine interim and settle-up payment rates according to items A to J.

A. A newly constructed nursing facility, or one with a capacity increase of 50 percent or more, may submit a written application to the commissioner to receive an interim payment rate. The nursing facility shall submit cost reports and other supporting information as required in parts 9549.0010 to 9549.0080 for the reporting year in which the nursing facility plans to begin operation at least 60 days before the first day a resident is admitted to the newly constructed nursing facility bed. The nursing facility shall state the reasons for noncompliance with parts 9549.0010 to 9549.0080. The effective date of the interim payment rate is the earlier of either the first day a resident is admitted to the newly constructed nursing facility or the date the nursing facility bed is certified for medical assistance. The interim payment rate for a newly constructed nursing facility, or a nursing facility with a capacity increase of 50 percent or more, is determined under items B to D.

B. The interim payment rate must not be in effect more than 17 months. When the interim payment rate begins between May 1 and September 30, the nursing facility shall file settle-up cost reports for the period from the beginning of the interim payment rate through September 30 of the following year. When the interim payment rate begins between October 1 and April 30, the nursing facility shall file settle-up cost reports for the period from the beginning of the interim payment rate to the first September 30 following the beginning of the interim payment rate.

C. The interim payment rate for a nursing facility which commenced construction prior to July 1, 1985, is determined by 12 MCAR S 2.05014 [Temporary] except that capital assets must be classified under parts 9549.0010 to 9549.0080.

D. The interim property-related payment rate for a nursing facility which commences construction after June 30, 1985, is determined as follows:

(1) At least 60 days before the first day a resident is admitted to the newly constructed nursing facility bed and upon receipt of written application from the nursing facility, the commissioner shall establish the nursing facility's appraised value according to subparts 1 and 4.

(2) The nursing facility shall project the allowable debt and the allowable interest expense according to subparts 5 and 7.

(3) The interim building capital allowance must be determined under subpart 8 or 9.

(4) The equipment allowance during the interim period must be the equipment allowance computed in accordance with subpart 10 which is in effect on the effective date of the interim property-related payment rate.

(5) The interim property-related payment rate must be the sum of subitems (3) and (4).

(6) Anticipated resident days may be used instead of 96 percent capacity days.

E. The settle-up property-related payment rate and the property-related payment rate for the nine months following the settle up for a nursing facility which commenced construction before July 1, 1985, is determined under 12 MCAR S 2.05014 [Temporary]. The property-related payment rate for the rate year beginning July 1 following the nine month period is determined under part 9549.0060.

F. The settle-up property-related payment rate for a nursing facility which commenced construction after June 30, 1985, shall be established as follows:

(1) The appraised value determined in item D, subitem (1), must be updated in accordance with subpart 2, item B prorated for each rate year, or portion of a rate year, included in the interim payment rate period.

(2) The nursing facility's allowable debt, allowable interest rate, and allowable interest expense for the interim rate period shall be computed in accordance with subparts 5, 6, and 7.

(3) The settle-up building capital allowance shall be determined in accordance with subpart 8 or 9.

(4) The equipment allowance shall be updated in accordance with subpart 10 prorated for each rate year, or portion of a rate year, included in the interim payment rate period.

(5) The settle-up property-related payment rate must be the sum of subitems (3) and (4).

(6) Resident days may be used instead of 96 percent capacity days.

G. The property-related payment rate for the nine months following the settle up for a nursing facility which commenced construction after June 30, 1985, shall be established in accordance with item F except that 96 percent capacity days must be used.

H. The property-related payment rate for the rate year beginning July 1 following the nine month period in item G must be determined under this part.

I. A newly constructed nursing facility or one with a capacity increase of 50 percent or more must continue to receive the interim property-related payment rate until the settle-up property-related payment rate is determined under this subpart.

J. The interim real estate taxes and special assessments payment rate shall be established using the projected real estate taxes and special assessments cost divided by anticipated resident days. The settle-up real estate taxes and special assessments payment rate shall be established using the real estate taxes and special assessments divided by resident days. The real estate and special assessments payment rate for the nine months following the settle up shall be equal to the settle-up real estate taxes and special assessments payment rate.